

THE PATIENT PROTECTION ACT OF 2000

HEARING BEFORE THE COMMITTEE ON COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED SIXTH CONGRESS SECOND SESSION

ON

H.R. 5122

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(III)

THE PATIENT PROTECTION ACT OF 2000

WEDNESDAY, SEPTEMBER 20, 2000

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
Washington, DC.

The committee met, pursuant to notice, at 10:10 a.m., in room 2123, Rayburn House Office Building, Hon. Tom Bliley (chairman) presiding.

Members present: Representatives Bliley, Tauzin, Oxley, Bilirakis, Upton, Stearns, Gillmor, Largent, Ganske, Norwood, Coburn, Cubin, Shimkus, Fossella, Bryant, Dingell, Markey, Pallone, Brown, Rush, Eshoo, Stupak, Engel, Sawyer, Green, Strickland, DeGette, Barrett, Luther, and Capps.

Staff present: Charles Symington, majority counsel; Marc Wheat, majority counsel; Kristi Gillis, legislative clerk; Bridgett Taylor, minority professional staff; Brendan Kelsay, minority professional staff; and Chris Knauer, minority professional staff.

Chairman BLILEY. The committee will come to order. The Chair recognizes himself for an opening statement.

Today, we hold this hearing to examine H.R. 5122, the Patient Protection Act of 2000. The Patient Protection Act opens physician information in the National Practitioner Data Bank to the public via the Internet free of charge. In doing so, it gives patients a fundamental new tool, access to important information about their doctors.

During my 20 years in Congress, I cannot remember an issue as simple as this. The question is, do patients have a right to know whether their doctor has a history of malpractice payments and disciplinary actions?

At an earlier hearing on this subject, we heard testimony from a young woman, a dentist herself, who was butchered by her OB/GYN. He carved his initials on her abdomen. This man, Dr. Allen Zarkin, continued to practice medicine for another 5 months before his license was revoked.

I ask my colleagues, do you not think patients had a right to know about Dr. Zarkin's conduct? If it was your wife or husband or daughter, would you not want to know?

I also understand that two of the doctors who are the subjects of victim testimony today, are currently practicing. When will this end? I believe consumers have a right to this information.

In many other instances where the health and safety of American consumers may be at risk, Congress often requires that information about such risks be made available to the public. Consumers have as much right to know about their physicians' profes-

sional backgrounds as they do about the ingredients in a snack food. Nowadays, most consumers are forced to choose a physician from a list of providers or even the Yellow Pages, doctors they might know next to nothing about.

The Federal Government already collects a large amount of useful information in the National Practitioner Data Bank, a data bank that was created with taxpayer dollars a decade ago. The Data Bank contains the exact kinds of information that consumers would want to know before choosing a doctor—disciplinary actions and medical malpractice payments. Whether we are speaking of parents expecting the birth of their first child, a family choosing their primary care physician, an individual selecting a surgeon before a major operation, or a senior citizen relying on a practitioner for her unique health care needs; all patients should have the tools to know whether that doctor has a prior history of medical malpractice payments, disciplinary sanctions by States' licensing boards, or sanctions by hospital peer review boards.

Why has this information been kept from consumers for more than 10 years? Because special interest groups here in Washington, DC, have fought to keep it out of the hands of the American people. I will not stand for this, and neither will the American public. Doctors routinely require consumers to give patient histories before treatment. I think patients should have the right to obtain physician histories before placing their very lives in the hands of a doctor.

This is why I have introduced the Patient Protection Act. What information will consumers have access to when this bill becomes law? The Data Bank's disciplinary information, consisting of adverse actions taken against physicians' licenses and hospital privileges, will be disclosed in the form that it is currently maintained in the data bank, with minor changes. Also, medical malpractice payment information, which consists of judgments and settlements, will be disclosed with explanatory information to compare physicians by specialty and by State.

By placing the medical malpractice payment information in context, the bill strikes the right balance between the needs of patients and the needs of physicians. The bill also makes one important addition to the Data Bank. It expands the National Practitioner Data Bank to include felony and certain misdemeanor convictions of physicians, information not currently collected by the Data Bank.

I want to address the arguments made by those opposing the bill. First, opponents claim consumers should not have access to this "raw" data and that it is not useful as an indicator of quality of care. If this is the case, then why did Congress mandate that this information be collected in the first place and used by hospitals and State licensing boards for the past decade in making hiring decisions and competency evaluations? If it is relied upon by these professionals, why can it not be relied upon by the American people?

Opponents also argue that consumers would not understand the information in the Data Bank, that it would be misinterpreted by the average citizen. I reject the claim that consumers cannot be trusted to understand and use this information. With that said, the

bill discloses medical malpractice payment information in context to consumers.

Another attack on this bill comes dressed up as States rights. The AMA has opposed this bill on the basis that States should report the information to consumers. The bill is modeled on the State efforts. Let me be plain. If the AMA supports access to this information at the State level, why not at the national level? Why would you want to limit the American public to a hodgepodge of systems, capturing different types of information, rather than one complete, consistent source that already exists? Unfortunately, this is merely another disingenuous argument made by the AMA. We have seen before that the AMA State counterparts fight to weaken legislation at the State level to block access to this information.

Some also argue that doctors may be unfairly reported to the Data Bank. That is easily addressed. There is an appeals process currently in place, and the bill provides physicians additional safeguards by offering them the opportunity to submit a statement of their own creation to give their side of the story.

I have also heard the argument that, due to hospital under-reporting, the data in the NPDB is not accurate. First, the fact that some hospitals may fail to report does not affect the quality of the data already contained in the Data Bank. In fact, we devoted an entire hearing in March of this year to the administration of the Data Bank and heard testimony from HHS that there is no problem with information quality.

Second, hospital discipline comprises merely 4 percent of the Data Bank records. Despite all the inside-the-Beltway chatter, I have pursued this issue for one reason only, it is sound public policy. Given the remarkable growth and advances of Internet communication, we now have the ability to give the public, with the click of a button, access to useful information about their doctors; days, hours, even minutes before an appointment. The soundness of this policy is demonstrated by looking at the diversity of the groups that are supporting this legislation. We are building a broad coalition that transcends traditional liberal versus conservative ideology. The reason? This is the right thing to do.

I implore you, don't allow certain Washington, DC special interests to keep this critical information from consumers. There may be some opposition voiced to this legislation today, but I would urge my colleagues when they are back in their districts to ask their constituents whether they would want this sort of information before seeking medical treatment. The answer of course will be, yes, they do. I urge you to give it to them.

Let me conclude by saying I do not think there is a more honorable profession than the practice of medicine. I have enjoyed the support of the AMA and many physicians from back home in Richmond during all of my campaigns for Congress. I continue to hold the medical profession in the highest regard. This legislation is about protecting patients, not targeting doctors.

I think the vast majority of practicing physicians are good physicians. I also believe the vast majority of physicians agree with the more than 90 percent of the American people who believe disclosure of this type of information is an idea whose time has come.

I would like to thank all of the witnesses for appearing before the committee today, and I look forward to hearing their testimony.

The Chair now recognizes the gentleman from Michigan, Mr. Dingell.

Mr. DINGELL. Good morning, Mr. Chairman, and thank you for recognition. This is an important topic, and it is an important hearing. I regret that you and I will have some modest differences in views on this legislation, but I will work with you to try and perfect it and see to it that we get information rather than raw and doubtful data to the consumers of medical services.

I think it is unfortunate that the timing of this committee's interest in this matter has triggered fears by many that there is some retaliatory approach here against doctors for their steadfast support for a comprehensive and enforceable Patients' Bill of Rights.

The relative swiftness of action here also has been commented on by many as standing in stark contrast to the absence of committee work on Medicare prescription drugs, the Patients' Bill of Rights itself and protecting children from tobacco addiction. But, in addition, our witnesses are here today to talk about what is a very real problem, and I want to make it clear that my personal respect and affection for you does not indicate any lack of trust, affection, or respect for you.

I will note that there are a relative handful of bad health care practitioners. They do hurt people, and I think it is important that we should talk about possible remedies for this and seeing to it that American consumers are armed with good information, rather than with speculative and doubtful and unevaluated data which contributes nothing to their real judgments as to who it is should care for them or whether they are receiving proper care from responsible people in the professions.

I want to thank the many witnesses that have traveled great distances to be with us here today. In particular, I would like to acknowledge those individuals on the first panel that are willing to share with us some of the very tragic experiences that they have had to either themselves or a loved one. Every member in the room not only appreciates your willingness to come here but also sympathizes with your losses and concerns.

What I hope today is that all will understand, however, that our problem is to come to agreement on the best kinds of information that will assist the public to best address how they will make informed decisions about their medical practitioners and the quality of their medical care.

Opening the National Practitioner Data Bank is not without controversy. Those that seek open access by the public argue that consumers have the right to make informed decisions. I am in accord with that. Others argue that a haphazard use of such information can be grossly misleading in its ability to predict either doctor quality or competence or to assure the patients that they are going to receive proper treatment. It is also argued that open access may punish practitioners who have been willing to engage in treating special high-risk populations or those willing to provide certain high-risk procedures.

What we also hear is that the Data Bank also suffers from serious underreporting by certain categories and that its contents

should not and cannot be solely relied upon as a single factor for determining whether a doctor is trustworthy, competent or harbors great evil and danger to the consuming public.

The question before us is whether opening the NPDB is the appropriate way to start getting more information to consumers. There is also the question of whether NPDB is, in fact, a device which has achieved the perfection that will both assure the consumers of proper treatment and information but also assure the practitioners that they are being fairly treated. Because a person's good name is perhaps their most valuable, treasured and cherished possession.

First, it is my understanding that many States now attempt to provide a systematic approach to publicly accessible doctor profiling systems. Already, according to the Federation of State Medical Boards, more than half of State licensing boards have begun physician profiling systems whereby information on physician licensure, medical education and training, disciplinary actions, criminal convictions and the like have been assembled.

I think we need to know, how good are these efforts? Do they really contribute to the well-being of the patient? Do we know enough about these State efforts to reject them as a key to the approach to solving this problem? Do they, in fact, work and advise the consumers properly and do they solve the problem? Would a nongovernmental clearinghouse work here or would it be inadequate?

Second, what about underreporting by key segments to the Data Bank? We do know that certain segments for whatever reason do not report as frequently as they should. For example, almost 60 percent of the hospitals have never filed a single report with NPDB. How is that possible, and what are the implications for finding out the potential for misleading information if the Data Bank were opened to the public? Does the bill address this properly and adequately?

Third, do we really ultimately address the issue of presenting data as sensitive as malpractice claims on doctors fairly and in a way which truly reflects competency or quality when insurance companies often force settlements? How will a doctor with two or more specialties, one perhaps high-risk, be presented to the public if he has a malpractice settlement in one of these categories? Will the data be presented in a way that properly weights the portions of the particular physician specialty in a way that does not unfairly characterize ability? What about doctors who perform innovative yet risky and necessary procedures? These categories are prone to greater malpractice exposure, yet it is not clear how the bill would place a related malpractice claim in proper context.

Finally, today's risky procedure is tomorrow's low-risk procedure. Because records stay in the NPDB for life, how will once-risky procedures where a malpractice claim was involved be viewed by the public many years later? Moreover, because malpractice claims do not reflect a peer review process, is it wise that this should be the dominant indicator used by the public to choose or reject a practitioner?

Finally, let's address the question of costs. Would it transform a Federal program, once mostly self-financed by users fees, into a po-

tentially costly program financed by the taxpayer? Does it make sense to spend considerable time and resources retooling a data repository that was never intended to be used in this fashion? Or does it make more sense to develop a new program, possibly at the State level, possibly at the Federal level, which will provide the most reliable and best information to the public so that the best judgment may be made by the patient?

These are among the many questions that should be answered before this legislation moves forward.

I thank the witnesses today and look forward to their testimony; and, Mr. Chairman, I look forward to working with you, my good friend, to achieve a satisfactory result to the difficulties we confront today.

Thank you.

Chairman BLILEY. I thank the gentleman, and I look forward to working with him.

The Chair will announce that, without objection, all members may insert a statement in the record. It is also the chairman's intention to recognize the members in order of appearance; and at this time I recognize the gentleman from Michigan, Mr. Upton.

Mr. UPTON. Thank you, Mr. Chairman. I am going to put my full statement as part of the record and try to summarize it briefly.

[The prepared statement of Hon. Fred Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM
THE STATE OF MICHIGAN

Mr. Chairman, we are going to hear from three individuals today who have had terrible experiences with our health care system. No health care system—and particularly one that is touted as offering the most sophisticated, finest quality of care in the world—should tolerate such conduct or permit such incompetence.

I think we all share a common goal here this morning. We want to prevent these horrific cases. We want to ensure that all Americans receive high quality health care, that all Americans can have faith that the doctor who is operating them or their loved ones is competent, and that all Americans have the information they need to make informed choices of medical practitioners.

I am not at all convinced, however, that opening the National Practitioner Data Bank is the answer to reaching the goal we share. First, malpractice is not an especially good proxy for judging competency. From its inception, the data bank was intended to be an additional tool for states, hospitals, and insurers engaged in licensing and credentialing decisions, not as a tool for use by the general public in evaluating physician competence. The number and even the size of malpractice payments may not necessarily indicate a doctor's competence. Insurance companies often settle out of court rather than go to trial even though there is compelling evidence that the physician's care was appropriate. Doctors who take on the toughest cases because they are highly skilled may have more malpractice suits than others in their field. Doctors who are in high-risk fields, such as obstetrics and neurology, may face more suits than their peers in other areas of medicine. Doctors who are engaged in cutting edge clinical research to develop and perfect what will be tomorrow's routine standard of care may also have higher rates of malpractice suits.

One has to wonder how many physicians, had they known that Congress would open the data bank to the public, would have fought malpractice suits through the court instead of settling them? This calls into serious question the reliability of the data bank as a tool for assessing physician competency.

Opening the data bank to the public—including trial lawyers—could well discourage doctors from going into high-risk fields of medicine, from delivering babies as part of their family medicine practices, and from engaging in clinical research. These are outcomes that will reduce, not enhance, access to care and quality of care. Opening the data bank could well undermine our nation's pressing need to reduce medical errors.

From its inception, the data bank was intended to be an additional tool for states and hospitals and other health care providers engaged in credentialing decisions,

not as a tool for use by the general public in evaluating physician competence. Opening the data bank to the public—including trial lawyers—could discourage doctors from going into high-risk fields of medicine, from delivering babies as part of a family practice, or from engaging in clinical research. These are outcomes that will reduce, not enhance, access to care and quality of care both now and in the future.

Opening the data bank could also undermine our pressing need to reduce medical errors in our nation's health care delivery system. In its 1999 report, the President's Quality Commission noted that current systems to improve the quality of care tend to focus too much on individual practitioners and not enough on *system* problems. That was brought home in a very dramatic way by the Institute of Medicine's report on building a safer health care system, *To Err is Human*. This report came to the startling conclusion that anywhere from 44,000 to 98,000 people die each year as a result of medical errors caused largely by failures or glitches in systems of care. The report notes that more people die from medical errors in a given year than from motor vehicle accidents, AIDS, or breast cancer.

The report's major recommendation for correcting these problems in the system is the reporting of errors—both serious errors resulting in death or serious harm and less serious errors or “near misses” that if uncaught, could have resulted in serious harm. The report notes that effective reporting programs require the fostering of a climate that encourages individuals to come forward and report errors rather than covering them up out of fear of individual punishment or liability suits. The IOM report recommended a nationwide mandatory system for reporting serious errors with public disclosure and a voluntary reporting system for less serious errors that would be protected from public disclosure and litigation. However, the Agency for Health Care Research and Quality, in its review of the report, came down against any mandatory reporting requirement—finding that it could make matters worse and *that allowing disclosure of hospitals' and practitioners' names would be counterproductive*.

I agree with the Agency for Health Care Research and Quality. When we created the bank, we assured doctors that we would not open the bank to the general public, because the information requires interpretation and because it could result in an explosion of malpractice suits. If we break this commitment, how can we expect doctors and other health care providers to trust us when we tell them that if they come forward and report errors, they will not be singled out for punishment or be opening themselves up wide to malpractice suits?

If we want to correct the serious problems in our health care delivery system that undermine quality of care for tens of thousands of Americans every year, and if we agree that confidential voluntary reporting systems are the key to fixing our health care systems, then we had better think very carefully about the message we'll be sending if we open the Data Bank to the general public.

The states, rather than the federal government, have historically and appropriately had the responsibility for licensing and regulating health care providers to ensure that their residents are receiving high-quality services from competent, well-trained practitioners. As we will learn today, some states have already implemented comprehensive physician profile systems which are specifically designed to provide useful information to the general public, and other states are moving in that direction. Further, it is my understanding that the Federation of State Medical Boards is in the process of developing a comprehensive national physician profile system that is expected to be in place within a year or so. These systems are designed for public use and will provide consumer-friendly information on all physicians licensed in the states and the nation. By contrast, the National Practitioner Data Bank includes only those physicians who have been subject to disciplinary actions and malpractice suits,

Rather than trying to turn the National Practitioner Data Bank into something that it was never intended to be, I hope that we will work with the states to promote comprehensive physician profile systems and with the Federation of State Medical Boards in that organization's creation of a national, comprehensive, consumer-friendly data base on all licensed physicians in the United States.

Mr. UPTON. First of all, we are going to hear from three individuals this morning about tragic experiences that they or their loved ones have had with our Nation's health care system. No health care system should tolerate such conduct or permit such incompetence. We all share a common goal of preventing such horrific cases and ensuring that all Americans have the information that they need to make informed choices of medical practitioners.

But I am not at all convinced that opening the National Practitioner Data Bank is the way to reach that goal. In fact, it could well work against improving the quality of health care in this Nation, and there may be better and more timely ways to provide the general public with the information needed to make informed choices.

First, I would point out that the number or size of malpractice suits and settlements is not an especially good proxy for judging competency.

Second, opening the Data Bank to the general public could work against our efforts to reduce medical errors and improve health care quality by discouraging physicians and other health care providers from reporting errors and working to eliminate the causes of these errors in our systems of care.

Third, it has always been the States, not the Federal Government, that has traditionally and appropriately had the responsibility of regulating, licensing health care providers and protecting consumers from incompetent and unlicensed providers. A number of States either already have in place or are working to put in place physician profiling systems that in fact provide comprehensive information, including all physicians licensed in the State, and are designed to be consumer friendly.

Further, the Federation of State Medical Boards is working with its members to create a national physician profiling program that will be open to the general public and specifically designed to provide the kind of information the public needs to make informed choices. This effort could well be up and going within even a year.

I would hope that, rather than trying to turn the National Practitioner Data Bank into something that it was never intended to be, that I hope we will work with the States and the Federation to promote and strengthen their efforts.

I yield back the balance of my time.

Chairman BLILEY. The time of the gentleman has expired.

The Chair now recognizes Mr. Brown.

Mr. BROWN. I thank you, Mr. Chairman.

I would especially like to thank our witnesses for joining us this morning and thank them for their courage and willingness to come forward.

Mr. Chairman, I am glad this committee is taking time today to look at the need for patient protections. It is tragic when patients are actually harmed by services that were supposed to help them, and it is unconscionable when that harm is avoidable. That is why so many Americans are passionate about the Patients' Bill of Rights—catch the similarity of title—about the Patients' Bill of Rights, legislation which we passed in this House but unfortunately has so far been buried by Republican leadership in conference committee.

Doctors are held accountable for the decisions they make. Information about malpractice suits is part of the National Practitioners Data Bank that has sparked the Chairman's interest, and I applaud him for that.

When it comes to health plans, there is no information to report because health plans are not held accountable for the decisions

that they make. In terms of protecting patients from harm, it is a black hole.

After more than 4-years this Congress has yet to pass a Patients' Bill of Rights. It probably does not surprise you, Mr. Chairman, that when you chose to call H.R. 5122 the Patient Protection Act and to move it as quickly as possible through committee, it struck some of us inside this institution and outside this institution as a bit ironic. That doesn't negate the importance of this hearing. We owe it to patients and providers to look carefully at the benefits and the drawbacks of opening up the National Practitioners Data Bank.

I wish, Mr. Chairman, other members, many on this committee and many from both parties who have put a great deal of time and energy into real patient protections over the years could have worked with you to put this legislation together. I also wish the Health Subcommittee would have been given the opportunity to review the legislation before full committee consideration.

This is a controversial proposal, obviously. Access to information is an important patient right, but access to incomplete, inaccurate, out-of-context information, even misleading information, does no good and could in some cases do significant harm.

This legislation was introduced without the benefit of proper review and input from Members on both sides of the aisle. As I mentioned previously, it was given a title that already is in use as shorthand for the Patients' Bill of Rights. Ideally, the Norwood-Dingell bill sponsored by a Republican and a Democrat from this committee—ideally, the Norwood-Dingell bill would be law, and then we could give up the title Patients Bill of Rights. Unfortunately, it is not law; and we still use the title Patients Bill of Rights.

I have heard from a number of physicians who point to the title as further evidence that H.R. 5122 reflects motives other than the sincere desire to protect patients from harm. I hope this is not the case.

I look forward to hearing from our witnesses who can shed light on the true intent of this bill and especially shed light on the impact of this bill.

I thank the chairman.

Chairman BLILEY. The time of the gentleman has expired.

The Chair now recognizes the gentleman from Ohio, Dr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman.

I think it is important to have hearings on medical errors, and we certainly had a lot of press coverage on the Institute of Medicine's report. If I have some time today even in this statement I may read part of the discussion from one of the two medical papers that the Institute of Medicine used.

Mr. Chairman, I would point out that our three guests today—the husband of a woman who died in surgery, a woman who had eye problems, visual problems after surgery, and I think the son of a gentleman who died in surgery—can actually make the point that opening up the National Practitioner Data Bank would not be helpful. Let me go into a little bit of detail about this.

Mr. Fernandez lost his wife from liposuction. They went to a plastic surgeon named Dr. Earl Matory who was recognized as a

good surgeon. They researched his credentials before they went to see him. I did not know Dr. Matory personally, but I know people who worked with him, and he had high respect in the community, the medical community, for being a technically excellent surgeon.

It is my understanding that Dr. Matory, in the course of his career, had four settlements or at least four suits brought, don't know for sure there were settlements because the National Practitioner Data Bank is closed, but let's assume that they were settled. What would that tell Mr. Fernandez if he had had access to that? It would tell him that Dr. Matory was right about in the middle of all the plastic surgeons in the United States, since the average plastic surgeon in the course of his career has a little over three settlements. I should point out that those settlements frequently are decided by the insurance company and may not have merit. So had the Data Bank been open I don't know that that would have given Mr. Fernandez that much more information.

What do we have with the case of Mr. Churchill? Well, Mr. Churchill had gastric bypass surgery. This is a high-risk procedure. The incidents of death from gastric bypass surgery is 1 to 2 percent. Now let's say that Mr. Churchill had access to the Data Bank and had been able to see that Dr. Butler had had a number of deaths. What would that have told him? We don't know, because we don't know how many patients Dr. Butler operated on.

I am told by gastric bypass surgeons that many gastric bypass surgeons will do eight to 10 gastric bypass operations a week. That could be 400 or 500 a year. If there is a 1 or 2 percent mortality rate associated with that, in the best of hands that could be a surgeon could have 4 or 5 deaths per year from that operation per year, not over the course of 10 or 15 years. So that you wouldn't know for sure what that meant because you wouldn't know what the denominator was.

That brings me to Ms. Hachey.

I just talked to a corneal surgeon yesterday. The incidence of complication from radial keratotomies is probably about 5 to 10 percent in terms of problems, problems with glare, problems with night vision. We even have a Member of Congress who had radial keratotomy has lost part of his vision because of that. There is about a—maybe as much as a 2 or 3 percent incidence of loss of best corrected vision after the surgery, even with contact lenses or corrected vision. That is normally discussed in preoperative consent forms.

I don't know if that happened in your case, but what we don't know about your doctor is what was the denominator, how many patients did he operate on and then what was the incidence of complications. Had the Data Bank been open, you might have seen that he had 4 or 5 suits, but without knowing his total operative experience, you wouldn't know what context to put that in. He could have been the best, might have had a problem.

In other words, simply having access to that raw data doesn't give you an accurate index.

Now, if the chairman is proposing that we set up a Data Bank that includes every treatment for every patient—every psychiatric patient, any complication, every surgeon, every operation so that you have the denominator—then we are then creating an intrusive-

ness in the privacy of patients that would be far beyond anything we have ever discussed in terms of gun registration. That is a basic fundamental problem with the chairman's bill and part of the reason why I think the chairman only has two cosponsors to his bill.

And I would point out that there does seem to be a bit of irony in the fact that I had a Patient Right to Know bill with over 300 cosponsors and I couldn't even get a hearing or a markup in this committee on it.

With that, I yield back.

Chairman BLILEY. The time of the gentleman has expired.

The Chair recognizes the gentleman from New Jersey, Mr. Pallone.

The Chair would also ask the members to, in deference to our witnesses today, to try to keep their opening statements as brief as possible.

Mr. PALLONE. Mr. Chairman, I want to talk about the substance of this legislation, but let me just say before, I know some of my colleagues have talked about coincidences and innuendo and irony here today, but I will be very blunt. I have absolutely no doubt that the reason this hearing is being held today is because the Republican leadership in the House is trying to retaliate against the AMA and other health care professional organizations because of their support of the Patients' Bill of Rights.

Chairman BLILEY. Would the gentleman yield?

Mr. PALLONE. Let me say, Mr. Chairman, I am not suggesting that you are the one that is at fault here. I think many times what happens, particularly as we get close to the election, is that the House leadership basically steps in and says, look, this is what we want to have done; and you know the committee members on the other side of the aisle don't really have a choice because they want to send a message. The AMA opposed the Patients' Bill of Rights. The AMA doesn't want real effective HMO—the AMA wants effective HMO reform so they got to pay the price by bringing up this bill and retaliating against them and bringing up malpractice and the data base and all these other things here today.

Chairman BLILEY. Would the gentleman yield?

Mr. PALLONE. I will yield briefly. I don't want to use up all my time.

Chairman BLILEY. I will give you the time that you need.

In my 20 years service in this Congress, I have never had my motives questioned. I would remind the gentleman that I was the gentleman who subpoenaed the tobacco company records, put them on the Internet, even though the tobacco companies are among the largest employers in my district. And so I am disappointed that he would even suggest that my motives might be questioned.

With that, I yield back to him; and if he wants to discuss my integrity I will be glad to continue the discussion.

Mr. PALLONE. Mr. Chairman, let me explain, I am not talking about your integrity, and I am not saying that you are badly motivated. But I am just saying that I know that the House leadership—and it has been said many times in the media that the House Republican leadership is very upset with the AMA and the doctors' organizations because they were so supportive of the Norwood-Dingell bill, and I have no doubt that a tremendous amount

of pressure was brought to try to have this come up 1 month before the election. But let's hope for the best and hope that this is just a little blip and it doesn't go anywhere. Because, frankly, I think that the legislation, although there are some reasons to deal with legislation of this sort, that this particular bill is not the way to go.

Any effort to make more information about physicians available to consumers has to be presented in the context that paints an accurate picture. Information about malpractice, for instance, is difficult to present in an appropriate manner for a number of reasons. Insurance companies often settle cases brought against doctors because it makes sense from a business perspective and not because the physician in question has done something wrong. Malpractice settlements occurring in different States are difficult to compare as the laws vary from State to State and can therefore have very different meanings that may not be readily apparent to a consumer looking at numbers on the Internet.

Some specialties, moreover, are more prone to lawsuits than others, a fact which can skew the way information is perceived if it is not presented in the appropriate context. So if malpractice information which is required to be reported to the National Practitioners Data Bank that H.R. 5122 proposes to open to the public is not presented in an easily understood and appropriate context, consumers could easily draw erroneous conclusions about a doctor's competency and history. Such an occurrence would defeat the whole purpose of making such information available in the first place.

This is just one example of what is a very complex problem that I am concerned H.R. 5122 simply glosses over. The terrible instances of patient abuse that have been reported in the media and that we will probably hear about today, without questioning them, let Congress examine ways to increase consumer access to information about physicians and take action to do so.

Although the awareness H.R. 5122 raises about the need to address the questions surrounding the public's right to know is valuable, the legislation itself ignores the complexity of developing a system that makes this information available to the public in a way that is truly beneficial to the public's health. A much more balanced approach between consumers' right to know important information about their doctors and the manner in which that information is made available to the public is needed, as is a much more exhaustive examination of this complex issue by this committee before we move to markup.

Let me say in conclusion, you know we still do not have the Patients' Bill of Rights passed, and I am beginning to wonder every day, as one of the conferees, whether that is going to happen, and it is because of the Republican's intransigence on the issue. Again, I think that bringing up the Patient Protection Act, which is very similar in name, in some ways trying to suggest there is some tradeoff between the two, and as much as I understand that the people on the other side are motivated on this committee by good reasons, I have no doubt about what the House leadership is all about here today in trying to retaliate against the medical profession.

Thank you, Mr. Chairman.

Chairman BLILEY. The time of the gentleman has expired.

The Chair now recognizes the gentleman from Florida, Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman.

And I would say to my colleague, Mr. Pallone, he talks about the Patients' Bill of Rights not being passed by Republicans. We had the Coburn-Shadegg bill that we presented to the House floor. We voted on it. Unfortunately, it did not pass. Many of us do support the Coburn-Shadegg bill which we felt was the appropriate way to do this. So to hear folks, Mr. Chairman, on that side say that this whole hearing is because the Norwood-Dingell bill is not the correct way—because we had both alternatives presented on the House floor, and the Norwood-Dingell passed, but the Coburn-Shadegg didn't, and so this is just democracy in action.

So, in this case perhaps you didn't agree with the process.

Mr. PALLONE. Would the gentleman yield briefly?

Mr. STEARNS. Yes.

Mr. PALLONE. I understand the differences between the bills, but the bottom line is the conference is going nowhere, and the essence of trying to get something passed is compromise. So if you feel on your side that we need to pass something between now and when we adjourn, exercise, maybe send a letter or do something to pressure the conferees to meet again and try to come up with something that we can all live with. That is not happening.

I yield back.

Mr. STEARNS. But if the gentleman had made that point, I could understand. But the point the gentleman is trying to make, that this is a partisan thing, and it isn't. Everybody has a fair understanding of the issue and has lined up on either side. Just because people don't line up on your side doesn't mean that the leadership is motivated one way or the other. It is just that many members believe that Coburn-Shadegg was the proper way to address the issue, and you feel the Norwood-Dingell is.

Saying that, Mr. Chairman, the Institute of Medicine's 1999 report, *To Err is Human*, was indeed jarring. I think we all agree with that, and it is a real cause for alarm. In fact, in direct response, the Commerce Committee and Committee on Veteran Affairs, where I serve, have had joint hearings to look at safety in medicine. All the witnesses in these hearings agree that we must find ways to improve safety, and the general consensus was that this could best be achieved by creating a culture of safety that would require improving the system, and so we have to be careful not just to assigning blame.

While the 1999 Institute of Medicine report did not recommend opening the NPDB to consumers, I do believe patients deserve some knowledge of the physician's history of practice. However, because of the complexity of the issues involved, as Dr. Ganske has pointed out, including privacy, the consumer's ability to understand the information available through NPDB and the role of the State licensure boards, to name but a few. We must be extremely cautious, my colleagues, in whatever actions or recommendations we take today or in the future. We want to ensure that patients are

fully informed and fully understand the information that is being provided to them.

The only thing that Congress can do at the moment is to find a reasonable approach to determine to what extent the history of a physician should and must be revealed. Because the issues involved are so sensitive and because we want patients to have confidence in their doctor's ability, we must not allow emotions to overshadow our judgment. To put it more succinctly, this hearing should not lead us to a rush to judgment on the solution.

During the joint hearing we held last February on medical safety, one of the witnesses, Dr. Golden, representing the American Health Quality Association, testified, "reports identifying specific providers and individuals should generally not be disclosed. Part of the reason for this is that naming names tends to fix blame even when this is inappropriate. The IOM report on page 55 noted complex coincidences that cause systems to fail rarely have been foreseen by the people involved. This suggests that it is more important to understand system failures than attempt to fix blame on one or more individuals involved in this system failure."

After all, health care delivery involves a myriad of circumstances, including but not limited to the health care providers. All of my colleagues want to have the ability to find out whether or not doctors are reputable for our constituents and, frankly, whether they have a good track record. We all understand that, but let's make certain that in our effort to improve the quality of health care that we do so in a thoughtful and careful manner.

Thank you, Mr. Chairman.

Chairman BLILEY. The time of the gentleman has expired.

The Chair now recognizes the gentleman from Michigan, Mr. Stupak.

Mr. STUPAK. Thank you, Mr. Chairman; and I will be relatively brief.

The national data base was created or established to provide an information clearinghouse to collect and release certain information related to health care competency and conduct of physicians, dentists and, in some cases, health care practitioners. Information contained in the data base is intended to direct discreet inquiry into and scrutiny of specific areas of a practitioner's license, professional society memberships, malpractice payment history and record of clinical privileges. It was intended that the information contained in the national data base would be considered together with other relevant information and data in evaluating a practitioner's credentials. It was never intended to replace traditional forms of credential reviews. It was intended to augment information already there.

If the Chair truly believes that patients have a right to know, then I hope they would join us in passing a real Patients' Bill of Rights where medical decisions are made by the health care provider and the patient and there is not limitations on access to health care. That is what we need, not medical decisions being made by people who are not licensed to practice medicine such as insurance executive accountants. I hope you would join us in supporting the Norwood-Dingell Patients' Bill of Rights.

Patients do have a right to know about their health care professionals. Licensing and regulations of those professionals are left up

to the States, not to the Federal Government. We license only for prescription drugs under the Food and Drug Administration.

The data base was not created to be used as an instrument to judge the competency of health care professionals. It was not to be used for public information. Let us develop a system that protects the consumer.

Should we be looking at a different data base? Mr. Chairman, I am sure you are aware there is a different data base that has been developed. It is called the Health Care Integrity Protection Data Bank. It is called HIPDB. HIPDB reports only adverse final actions brought by State and government agencies against practitioners. All the reporting categories provide information only after a government agency has taken an action against a provider.

I would be interested to know whether the information in HIPDB should be made available to the public. I think that is a document and a data base we should be looking at, not throwing open the general data base which was designed and used for other purposes, not to judge the competency of health care professionals.

With that, I would yield back the balance of my time.

Chairman BLILEY. The time of the gentleman has expired.

The Chair now recognizes the gentleman from Illinois, Mr. Shimkus.

Mr. SHIMKUS. Thank you, Mr. Chairman. I would be brief.

I think Mr. Dingell was correct in making sure that we identify the distinction between information and data. They can be two different things. The question lies in trying to find a balance between allowing patients access to the information they need to make informed decisions about their health care providers and in protecting the doctor's privacy so they will continue to take the high-risk patients and specialize in high-risk areas. This is what we have hearings for, to get answers to these questions.

I thank the panelists, and I thank the chairman for holding this hearing. I yield back.

Chairman BLILEY. The time of the gentleman has expired.

The Chair now recognizes the gentlelady from Colorado, Ms. DeGette.

Ms. DEGETTE. Thank you, Mr. Chairman. I, too, will be brief.

I think that we do need to have some way for patients to know what is going on with prospective doctors. However, I am concerned with this legislation that if you just simply look at raw data from the National Practitioner Data Bank patients may get an inaccurate—potentially a dangerously inaccurate view. In addition, we need to find ways to improve data collection, since many hospitals across the country have never reported actions against physicians to the present Data Bank. So if we rely simply on the information we have now we may in fact be punishing perfectly fine physicians, while physicians with real problems have never had their actions reported to the Data Bank.

A couple of additional problems with this legislation is that patients can only get information through the Internet, and all patients researching physicians may not have access to that method.

Second, we need to have—and Congressman Dingell talked about this, and I agree. There needs to be improved due process, and

there needs to be a review mechanism to make sure that this information is accurate.

Finally, there needs to be some way to communicate with patients about physicians serving high-risk patients that may have more incidences reported. I must say, I think my constituents would want to know this information, but it is only by interaction with a professional that patients can get the full picture. That is why I agree with my colleagues, we need the Patients' Bill of Rights passed. We need to have all of this done.

With that, I will yield back the balance of my time.

Chairman BLILEY. The time of the gentlelady has expired.

The Chair now recognizes the gentleman from Georgia, Dr. Norwood.

Mr. NORWOOD. Thank you, Mr. Chairman, for allowing me this time. I want to start by saying to the gentleman from New Jersey, Mr. Pallone, I don't agree with him at all that the Republican leadership is pushing this bill in order to get back at the American Medical Association because they are trying to protect their patients; and I almost can guarantee you that the Speaker of the House of Representatives, Denny Hastert, is not doing that. That is an incorrect statement.

In the 6 months since this committee first held a hearing on this subject, nothing has happened to change my mind on making the National Practitioners Data Bank public. It is still a very bad idea. Those of us in the professions, whether it be medicine or dentistry, are the people most interested in ferreting out physicians and dentists that are incompetent or unethical. That is a very bad thing for the profession itself, and we are most interested in that.

It is a shame to me that the committee staff of this committee would not even come talk to the three of us who have seen patients over the last 25 years and ask our opinion on how we might better get information to the public, because we are all interested in that. We just happen to think this is not a good way to do it.

In my view, the practice of medicine and dentistry is local, and I have made that view known many, many times in many forums over the past several years. When I was a practicing dentist, I was licensed by the State of Georgia, practiced in my local community and was subject to the malpractice laws and the dental licensing board in my State. In trying to address quality of care issues, it has always been my preference that we consider State and local approaches rather than the Federal cookie-cutter approach. Yet here we are today considering the idea that making the National Practitioner Data Bank public will help improve health care quality.

The problems with this approach ladies and gentlemen are twofold. First, it attaches a level of sophistication to the NPDB that is just simply not appropriate. Second, it ignores State-based approaches that make much more sense, and many are already in place today. Might we not have tried to help that along as a Federal Government?

The problems with releasing the NPDB are pretty well documented. The NPDB is simply gathering information. It shows no context of the information. It doesn't speak to the complexity of the different procedures. The information does not in any way explain the conditions behind judgments that are made in many cases.

As my colleagues Dr. Coburn and Dr. Ganske will attest, simply saying whether a judgment was rendered hides the incredible, complex decisions that doctors have to make each and every day. It was not the intent of Congress that NPDB be made public. The committee reports written by this very committee in 1986 make that very clear, that the information in the NPDB should only be available to those who understand its meaning and are charged with making decisions about professional conduct.

I strongly believe the State medical licensing board should have the primary role on governing the practice of medicine and dentistry. In many States, the State legislatures and the State medical boards are working together to proactively create a stronger role for the licensing boards. Might we not have helped that from up here? They are using the Internet, in many cases, to put important physician information on the web for consumers to be able to review at any time.

We should also look to the Federation of State Medical Boards as the appropriate venue for sharing information. Though underfunded, might we not have helped that from up here? They are the appropriate private sector mechanism to share information among and between States regarding physician and dentist profiling.

If there is a doctor out there who is incompetent or unethical, we do need a system that identifies him and make sure the public is adequately protected. We need to use organizations like the Federation of State Medical Boards to move information across State borders.

Mr. Chairman, simply opening up the NPDB is a bad idea that will not do one thing to improve quality of care. I hope that we will look to the States to build on existing processes to address the quality of care patients receive; and I frankly strongly encourage you, Mr. Chairman, to bring this bill up for a markup. I want the world to know how few members of the Commerce Committee will vote for it.

I yield back the balance of my time.

Chairman BLILEY. The time of the gentleman has expired.

The Chair now recognizes gentleman from Texas, Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. It is great to follow my colleague, Mr. Norwood, who brought up a bill on the floor last week that only got 12 votes to abolish the Boy Scouts' charter. So maybe we can do that in our committee like we do on the floor.

Mr. Chairman, I want to thank you for calling the hearing today. Back in March, the Oversight and Investigations Subcommittee held several hearings concerning the National Practitioners Data Bank by the Health Resources and Services Administration. These hearings, while thorough, left a number of questions unanswered.

Mr. NORWOOD. Mr. Green, would you yield just 30 seconds?

Mr. GREEN. I yield my time.

Mr. NORWOOD. You need to say that again. I didn't bring up any bill—

Mr. GREEN. I didn't say you did. I said we as a Congress brought up a bill last week on the floor.

Mr. NORWOOD. Now there two Georgians who brought it up, but it was Seth McKinney and John Lewis, not me.

Mr. GREEN. Let me correct it. Even though I didn't vote for the bill, we are a part of this process; and if somebody brings up a bill on the floor that is trying to embarrass a Member or embarrass us we are all guilty of the problem, whether Republican or Democrat and whether we voted the bill or not. Like I said, it only got 12 votes. I think that was pretty well stated. But I thought bringing this bill up in full committee was interesting, and so we could see how many votes we have against it like we did last week.

Today, we have this legislation for us that would open the NPDB to the consumer before—so they could ensure that they have the best information about the competency and medical history of their doctor. Sounds good, but as we have heard in our hearings, that is a flawed data base.

I read a September 10 article in the Washington Post about a New York doctor who confessed to a killing spree that spanned his career as a physician. I find Dr. Swango's actions to be horrific, and I sympathize with all the victims and their families that are here today, but I submit that if H.R. 5122 had been the law Dr. Swango's killing spree may not have even been reported.

I don't disagree that consumers should know who it is that is treating them in a clinic or emergency room. I do, however, question whether this bill is the right approach to solving the problem. I first think we need to correct the Data Bank information and make sure it is complete before we release it and that under current law it is not.

The NPDB was created because Congress was concerned about the increasing occurrence of medical malpractice litigation, and we sought to improve the quality of medical care by gathering information about doctors who had a greater number of malpractice suits. This would allow the consumer to be aware of the past history of their doctor and enable them to make an intelligent choice about whether or not they wanted to see him or her. I don't question what Congress enacted back in 1986, but in this legislation there is no end to the consumer's need to identify and choose the doctor who needs to provide the services they require.

I would say that while information about past practices of their physician is important, that information is useless if you have little or no control over selecting your own physician. Information about which doctors are good and which are not doesn't help patients if they don't have access to better doctors. Further, what good is access to the best physician if you can't pay for the prescription drugs that they prescribe? If we had the Patients' Bill of Rights that I cosponsored that could be moved from the conference committee, that would go a long way toward providing consumers with access to better doctors.

I follow my colleague from Florida and understand that there was a number of people who voted on the floor for the Coburn-Shadegg bill. The problem is, that provision lost; and when the conference committee was formed, not one Member of the Republican majority who voted for the Norwood-Dingell bill was a member of the conference committee, including our colleague here, Mr. Norwood. So that is why a Patients' Bill of Rights is so important. It has been vegetating in a conference committee for 10 months, and I don't know if, in the next 2 or 3 weeks, it will all of a sudden

wake up from its Rip Van Winkle sleep, but we need to pass that legislation.

Also, if the House would seriously consider providing prescription drug coverage for lower income and elderly Americans, patients and doctors would have access to the life-saving medications that many have been forced to do without in our country.

I also feel it is a concern because I have watched over the last few months and the problems we know with the Medicare corrections bill, the 1997 Balanced Budget Act, I would hope that our committee would be considering that instead of seeing Ways and Means dealing with it.

This legislative session is almost over, and these critical issues have yet to be seriously addressed by our House leadership. And while I believe the consumers have the right to know the truth about who is providing their care, they should also be able to pick their own doctor and hopefully fill their own prescriptions. There are a lot of issues that our 106th Congress haven't addressed, and this is one of the small ones.

I yield back, Mr. Chairman.

Chairman BLILEY. The time of the gentleman has expired.

The Chair now recognizes the gentleman from Tennessee, Mr. Bryant.

Mr. BRYANT. Thank you, Mr. Chairman.

Let me say very quickly, about the motivation for this bill, I know sometimes we do crazy things in Washington, but I find it very difficult to believe that we would bring forth a bill like this that is controversial, that has people on both sides, good folks on both sides that are for and against it, the AMA in this case against it, and it would surprise me that even though we make bad choices up here sometimes politically that we would climb a tree and try to poke the AMA in the eye at this point right before an election to make all the doctors in America mad at us. So I just refuse to accept those kinds of motivations behind the reason this bill is brought forward now. We like doctors on our side, and we certainly hope that during the election time they participate fully and make their own free choices.

The issue of prescription drugs—we are the Congress, the House of Representatives. It has passed a prescription drug benefit, and in terms of managed care, we passed that managed care bill out of the House. Obviously, there are different viewpoints around the Hill between the Senate and the House and conference committees and what the President might do, but we are making strides, we are taking efforts, and we are the Congress that has done these things, and so I think Congress can be commended for that.

But back to the real matter at hand today, we are here to talk about this bill and not try to politicize it too much and politic too much, although that never seems to be far away from anything we do up here. As an attorney that came out of practice, one that defended doctors and occasionally a dentist that was sued, I know that malpractice lawsuits can be very complicated. Settlements are made sometimes, and cases are tried, and it is a very complex situation, and this bill concerns me from that standpoint.

But I do want to thank the chairman for this bill and for calling this hearing and bringing in 16 witnesses that have varying view-

points and have different bits of information and experience they can bring to this Congress so that we can discuss this.

This bill may or may not be the solution to this situation, but it is certainly a start in bringing forth this hearing and having, again, people on both sides, from different perspectives of this issue testify, which eventually they are going to get around to today if we will all quit talking, I think is a great idea.

I might say, if this were to fail, one great alternative to this issue of dentists and doctors, competency and making sure we have good ones out there is to put Greg Ganske in charge of Iowa and Charlie Norwood in charge of Georgia and Tom Coburn in charge of Oklahoma, and I guarantee you the doctors and dentists there wouldn't want them on their backs and on their case and wouldn't have any problem in those three States. But not having I guess people like that in every State—although I do suspect we do have them in the other 47 States.

That was actually supposed to be humorous, but it didn't go over well. Is there some tenseness in the room?

With that said, Mr. Chairman, out of respect to our witnesses, I am going to cut my statement short. I don't have any better jokes than that, so I better stop while I am ahead.

Chairman BLILEY. The time of the gentleman has expired.

The Chair now recognizes the gentleman from Wisconsin, Mr. Barrett.

Mr. BARRETT. Thank you, Mr. Chairman.

Very briefly, I am pleased that we are here today, although I, like others, wonder exactly what we are hoping to accomplish at this late stage. It was my hope that we could be voting on a real Patients' Bill of Rights on the floor of the House of Representatives and get that done, because I think that is what the American people want.

Obviously, we have to remember that our prime concern is the patients, and there has been a lot of discussion as to what the motives are, but I think that we best serve the public if we keep our focus on the patients. So I hope as we listen to our witnesses today that we keep that in mind. And, with that, I would yield back the balance of my time.

Chairman BLILEY. The time of the gentleman has expired.

The Chair now recognizes the gentleman from Oklahoma, Dr. Coburn.

Mr. COBURN. Thank you, Mr. Chairman.

You know, just a couple of observations as somebody that is leaving here. You can certainly tell this is an election year, and I think it is a discredit to this body that we have had so much hammering on how do we demagogue an issue to gain political advantage. There is not any Member of the House that doesn't care about patients and their rights. There is not any Member of the House concerned that people can't afford prescription drugs. And to imply anyone, including leadership out of either side, is degrading to the House and serves no purpose except to increase the cynicism in this country.

Now, as far as the matter at hand, this is a State issue. If we are going to move all the control for all the professions to Washington, God help us. This has no business in Washington. And, no,

the States aren't perfect, but this is a right that should be reserved to the States. We should not grab this. We should not make it a change in this. I am not even sure that the National Practitioners Data Bank is a good idea.

The second point I would make is, of all the doctors I know, most of the doctors with the most lawsuits is who I want working on me. They are the ones who took the chances on people to save their lives; they are the ones who took the high-risk patients; they are the ones who took the ones that didn't pay and still got sued. That is who I want working on me. So we are going to have—if something like this happens, we are going to have exactly the opposite effect.

The third point I would make is, patients ought to be choosing their doctors based on referrals of other patients and no other basis. The personal interaction of a physician in caring for someone is both the best and the worst recommendation a doctor can have. If it is no good, you are not going to get other patients; and if it is good, you are going to get a ton. And we have a Soviet-run health care system in this country that someone will make worse by improving the lawsuit ability and the suitability—and then we have a system that we could make better if we could in fact give people back their choice of going to the doctor that they want.

So we have created this problem, and we ought to recognize it for what it is. We ought to reverse in our steps. We ought to allow patients to choose whatever physician they want, regardless of who is paying the bill; and once we do that we won't have a problem with quality.

One final note. The Institute of Medicine study, I would refer you to the analysis of that study. It is significantly erred in terms of errors, and with a study that has been published with that many errors in it about doctor errors and hospital errors, it needs to be thrown out and done again.

With that, I yield back.

Chairman BLILEY. The time of the gentleman has expired.

The Chair now recognizes the gentlelady from California, Mrs. Capps.

Mrs. CAPPS. Thank you, Mr. Chairman.

I didn't prepare an opening statement. I am here to learn and appreciate the discussion on all sides, but I will use this opportunity to urge my colleagues in this committee and on the floor to get busy and pass out of conference the Patients' Bill of Rights as we passed it in a bipartisan fashion in the House of Representatives.

Each weekend when I go home to my constituents who urge me to take an active role and support reform of managed care, they say, is our bill signed into law yet? So that is an issue that I would like us to address immediately.

I yield back the balance of my time.

Chairman BLILEY. The time of the gentlelady has expired.

The Chair now recognizes the gentlelady from Wyoming, Mrs. Cubin.

Mrs. CUBIN. Thank you, Mr. Chairman.

In order for us to make good decisions about our health care we need to know the facts and we need to assess the reliability of the

information that is available to us. When I choose a doctor for myself or for my family, I want to learn all that I can about the doctor's medical background, his qualifications and his reputation. I am married to a physician and have a son that will be a doctor in the future as well. This is my way of ensuring that I get the best care possible for myself and for my family.

The legislation that we are considering today, H.R. 5122, tries to build on this notion by making information in the National Practitioner Data Bank available to the public. While I do believe the intent of this bill is admirable, I have some serious concerns.

First, merely opening up the Data Bank to the public will not necessarily provide them with beneficial information in making health care choices. With all due respect and agreement, I might add to the chairman's opinion that we should not underestimate the American public in what they can and cannot understand. I still believe that it would be very easy for the general public to misinterpret the information in the Data Bank.

For one thing, the information in the Data Bank is in legalese, and that is something that isn't easy to understand. Sometimes doctors are forced to settle malpractice lawsuits not because they did anything wrong but because it is financially cheaper to do that for the insurance companies.

I happen to know of a case where a doctor was sued, and the insurance company said we will cancel your insurance if you don't settle, even though the insurance company knew very well that the doctor had done nothing wrong.

I saw a program on television about a patient who goes from doctor to doctor and then files lawsuits and settles for \$5,000, has never settled for over \$10,000 but has sued multiple times. So these doctors would have that information in the Data Bank.

The details behind any malpractice suit or any allegation or any criminal act or wrongdoing on the part of a physician would not be included in the Data Bank. So as a patient I would look at the physician profile that is in the Data Bank and see nothing but red flags and negativity, and that in some cases might not necessarily be the case with the physician. In fact, in the course of my treatment, I could be negatively influenced because of doubt that I would have about my practitioner.

In every medical procedure, in every one, there are possible complications, including death. Doctors who see more patients because they use nurse practitioners or physician's assistants will have a higher number of incidences on their record, a higher number of complications, but that doesn't necessarily mean they would have a higher rate of complications.

Second, as has been discussed also, many States have already established a physician profiling system. These systems are available to the public. If a particular State determines that such open accessibility is necessary, then why not let the State continue to make that decision? This bill tells us that the Federal Government is in a better position to make that decision, that open accessibility to the Data Bank for all will help us make better decisions about care, regardless of whether or not we have the whole story about the information that is contained in the Data Bank.

I think that we need some more time to carefully evaluate the consequences of opening up this Data Bank, and I look forward to the discussion today and stand by ready to work with all of the members on the committee.

I yield back the balance of my time.

Chairman BLILEY. The time of the gentlelady has expired.

The Chair now recognizes the gentlelady from California, Ms. Eshoo.

Ms. ESHOO. Thank you and good morning to you, Mr. Chairman. Just a few quick comments.

Much has been said about the chairman bringing this to the committee. We are all legislators, and we are all politicians. Most frankly, he is the chairman of one of the most powerful committees in the Congress. It is his prerogative to bring things forward and to use the power that has been given to him. We as legislators will discuss and debate and weigh in, and he has won some and he has lost some. So if this bill does not have merits to it and every member is speaking out about where they find the shortcomings and where they think the sun needs to shine in, that is really our process. And I really don't think much more needs to be said about it, even though a lot has, but that is the way I view it.

No. 2, I think that, yes, the bill does have shortcomings. We are contrasting what the States have in place and does the Federal Government have a role here.

Third, I have said many, many times that at the end of the day we all want the best physician standing on one side of us. And the best lawyer standing on the other side of us, and this committee today is going to get to stand next to physicians because a lot of members feel, myself included, that we need to be guarded about information that is put out that ends up being misinformation on the part of the healers.

Fourth, I think that we can benefit from the hearings and the documentation of the hearings that were held by one of our subcommittees, Oversight and Investigations, on March 1 and March 16 of this year.

Fifth, there isn't any member that isn't going to stand next to the sun shining in for consumers, consumer information, and I think that you are hearing some regret on the part of members here because there are several health care initiatives that really should be adopted for the people of our country.

There should be a full Patients' Bill of Rights. There should be prescription drug coverage in Medicare for our seniors. We should have developed a meaningful medical privacy bill to protect medical records in our country. But we still have some time left in this Congress. And, Mr. Chairman, if in fact what comes out of this hearing, added to the hearings of March 1 and March 16, move on into the 107th Congress, when you unfortunately will no longer be part of this body, and we can reshape it so that it is great for the consumer, great and important coverage for physicians in the country, I will be there to work on it.

Thank you for recognizing me.

Chairman BLILEY. The time of the gentlelady has expired.

The Chair now recognizes the gentleman from Oklahoma, Mr. Largent.

Mr. LARGENT. Mr. Chairman, in deference to time, I will yield back my time.

Chairman BLILEY. The Chair thanks the gentleman.

The Chair now recognizes the gentleman from Minnesota, Mr. Luther.

Mr. LUTHER. Well, thank you, Mr. Chairman. I will be brief as well.

I guess my first thought is that I don't completely understand why we would be dealing with this issue with just a couple of weeks before the conclusion of the session.

Previous to being here, I served in the Minnesota legislature, and we tended to focus during the session on the issues in committee. We tended to focus on the issues we were doing to deal with that session on the floor. It seems to me the issues we are dealing with this year are the Patients' Bill of Rights, prescription drug coverage; and I don't think anything we do here should take our focus away from those essential items that we are planning to get done this year.

But with respect to this legislation, I think it is highly appropriate that we look at this issue, and I assume that your purpose in bringing this forward this year is to set the stage for further hearings next year and some work during the next session.

There are just two comments, and I look forward to hearing the testimony and reading the record.

The two thoughts that immediately come to my mind are, first of all, I think consumers feel completely inadequate when it comes to picking professionals, whether it is a lawyer, doctor, or any professional. They feel very inadequate in doing that. They crave information. They would love to have very reliable information when it comes to choosing professionals. So I think it is good that we are looking at this issue of how can we help the consumers of America make one of the most important decision of their lives. So that is very, very good.

Second, I think the regulatory efforts of the States in this country from everything I know are notoriously bad in terms of helping the consumers of this country, and so I think it is a very worthy effort to look at how we can assist and find what States are aggressive and how we can get other States up to those levels and how we can assist this effort in the country to help consumers making these decisions and getting the appropriate discipline in place when there are incompetent professionals out there.

Those are the kinds of issues we ought to be looking at and working on in this committee, and I assume that today's effort is the beginning of that kind of a dialog, and I think that that is very good. And I hope as we go into the next session, assuming we get prescription drug coverage done this year and assuming we can get a Patients' Bill of Rights, I think it will be very good to go into the next session and start talking about issues like this in terms of how can we assist and be helpful to consumers in this country in making these kinds of decisions and then getting incompetent professionals out of the business. Those are very worthy goals; and I commend you, Mr. Chairman, on those goals. Thank you.

Chairman BLILEY. The time of the gentleman has expired.

The Chair now recognizes the gentleman from Florida, Mr. Bilirakis.

Mr. BILIRAKIS. Thanks very much, Mr. Chairman. I will be very brief.

I first want to welcome Ms. Gloria Crawford Henderson, who is the Director of the Division of Medical Quality Assurance for the Florida Department of Health, for being here and to welcome and thank all the witnesses. Mr. Chairman, as I am sure you know there is a phrase we use up here all the time, the concern of unintended consequences, and it is very critical that we listen and read the testimony of these witnesses to help us on this issue.

Yes, it is significant that you have brought this up, but it is a fact we do care about the patients. It is very, very important. We have to keep all that in mind, but the unintended consequences have to be there in our minds, also.

I see Mr. Green has not returned, but Mr. Norwood corrected him; and with all due respect, I am going to correct him. There is a member of this committee from this side of the aisle who voted for the Patients' Bill of Rights who is a conferee, and that should be made part of the record.

I yield back, Mr. Chairman.

Chairman BLILEY. The time of the gentleman has expired.

The Chair now recognizes the gentleman from Illinois, Mr. Rush.

Mr. RUSH. Thank you, Mr. Chairman. Mr. Chairman, I look forward to this hearing. I think this is a very important hearing, and I look forward to it.

Allowing the public access to the National Practitioners Data Bank will save lives and will ensure that the public has vital information about the incompetent performance of doctors. Nowhere is this information more vital than in a time of medical need. When a patient is faced with making important health decisions such as choosing a doctor, that patient should be allowed to have access to all the necessary information needed to make an informed decision. Such information is a matter of life and death. However, that information should not be based on flawed information. It should be based on reliable information.

Again, Mr. Chairman, I look forward to today's testimony regarding the pros and the cons of this legislation.

Mr. Chairman, I also want to add my voice that I believe that it is proper and appropriate that this committee do move forward or that this Congress move forward on the vital issues of prescription drugs and the Patients' Bill of Rights. I think that it is a travesty that we are engaged in developing and working on new legislation when this legislation that has been around for a while still sits and no action is being taken on it.

Mr. Chairman, I also want to add that I really have a concern that we don't move forward in this committee on this particular issue based on fear mongering. I just believe that we need to take a sober, broad-based, sound approach to discussing both pros and cons of this particular legislation; and, hopefully, this committee and this hearing will lead us down a path where we will be able to make some decisions and offer some corrective actions that will certainly benefit America's citizens and those who seek medical care.

Thank you, and I yield back the balance of my time.

Chairman BLILEY. The time of the gentleman has expired.

The Chair recognizes the gentleman from Ohio, Mr. Gillmor.

Mr. GILLMOR. I pass, Mr. Chairman.

Chairman BLILEY. The gentleman passes.

The Chair now recognizes the gentleman from Ohio, Mr. Sawyer.

Mr. SAWYER. Thank you, Mr. Chairman. I will try to be brief.

By way of summary, just let me say that I join my colleagues in offering deep condolences to our first panel. I have looked at the testimony, and the personal stories are compelling reasons why consumers must actively and aggressively research the physicians who treat them.

In Ohio, the Ohio State Medical Board has been aggressive in bolstering safeguards to protect patients from substandard care, often cited as one of the toughest in the Nation, and publishes information about physicians, including professional disciplinary actions by the board, but in doing so, they have high standards for consistent and full reporting.

The deepest concern I have about the action that we are taking today is that in a blizzard of information we are building in inconsistencies that may mislead rather than inform, and it is one of the elements of this legislation that I think needs to be addressed with care over time as we bring real consumer protections to the people of the United States.

With that, Mr. Chairman, I yield back the balance of my time and thank you for the opportunity to make this statement.

Chairman BLILEY. The time of the gentleman has expired.

The Chair now recognizes the gentleman from Massachusetts, Mr. Markey.

Mr. MARKEY. Thank you, Mr. Chairman, very much; and I want to thank you for having this very important hearing today on this very, very important subject.

While we all admire the medical profession, your bill helps to shine a spotlight on the need to stop rogue doctors who are traveling from State to State, running from their ruinous records and harming unsuspecting patients along the way, all as part of a scheme to stay one step ahead of their bad medical records. While these bad actors may be few in number, our first panel of witnesses will attest that having even a few bad actors can result in tragic consequences.

Let me be clear. I believe that in the overwhelming majority of cases American physicians are the best and the brightest, setting the world standard for quality of care. But if we want this system to remain strong, we must be willing to confront those who would undermine that system.

In addition, Mr. Chairman, we must recognize the personal and intimate nature of the patient-doctor relationship. That relationship is often initiated by the patient who has done his or her best to learn as much about the physician as possible through word of mouth and contacts with State medical boards. Should consumers be given as much information as possible so that they are making the best possible decisions? The answer of course is yes. We are talking about their families, probably the most important decisions they will ever make in their life.

Would the Patient Protection Act, as currently drafted, achieve that objective? I think it comes close to doing so. I think the critical question here is how it could be improved, what else we could add that ensures that we will, in fact, be able to achieve all of our goals; and I think with the able assistance of the panel we will be able to achieve that goal.

I am pleased that one of those witnesses is from my home State of Massachusetts. Nancy Achin Sullivan, Executive Director of the Massachusetts Board of Registration in Medicine, is here for the second time, actually, to describe the Massachusetts physician profile system, the means by which it was created and the success of its implementation. I want to thank you, Mr. Chairman, for inviting her here today and for using the Massachusetts system as the model for your legislation.

In Massachusetts, consumers have access to important information regarding their physicians, everything from background, degrees and professional awards to malpractice claims and disciplinary history. Interestingly, the system also contains information on which insurance plans the doctors accept and where their office is located. The Massachusetts system is available to consumers by way of the Internet and a 1-800 number where operators read the physician's profile to consumers over the phone and then send a hard paper copy to them in the mail.

H.R. 5122 is an important addition to the law. It does not include a 1-800 provision which I would like to see added; and, Mr. Chairman, I believe that if we could add that kind of a provision, an 800 number, that that would improve the bill mightily.

In addition, Mr. Chairman, I believe that there are other areas where this legislation could be strengthened. For instance, a public data base should include specific violations of each State's malpractice law and Criminal Code. Moreover, we must carefully examine the many privacy implications in the legislation. For example, if publicizing the precise dollar amount would allow a victim's privacy to be invaded, perhaps indicating that an award fell into a range of dollar amounts might be a better approach. And whether or not we make the data base public, we must urge States to develop their own systems to enhance the effectiveness of the using of the data as a tool for families.

Finally, Mr. Chairman, we must be mindful that this Congress has under active consideration a whole range of legislation; and, hopefully, this can be part of a package of legislation that enhances the power of families to protect themselves.

Mr. GANSKE. Would the gentleman yield?

Mr. MARKEY. I will be glad to yield.

Mr. GANSKE. I just noticed on C-SPAN the gentleman was listed as a Republican from Massachusetts. Is the gentleman making an announcement today?

Mr. MARKEY. Y'all probably don't understand, but when I arrived on this committee, before I was influenced by the chairman of this committee, I was a liberal Democrat from the State of Massachusetts, but now I am seeing the light of the way and starting to wear bow ties, actually, in my personal life, and the powerful influence of the chairman without question has changed my life, and perhaps that is what is being reflected out in public observation.

Although I will say this, I think that the chairman does have a very funny accent that he uses when he talks. I hate those regional dialects.

Thank you, Mr. Chairman. I yield back the balance of my time.

Chairman BLILEY. As usual, it is a hard act to follow; and I am glad I see none of my colleagues want to follow it. The Chair notes that there is a vote on the floor. The Chair notes it is also close to the noon hour. With that, the Chair is going to recess the hearing until one o'clock, at which time we will begin hearing from our panels.

[Brief recess.]

Chairman BLILEY. The committee will come to order.

When the committee broke for the previous vote, the Chair announced that the opening statements are over; and they are. Any member that didn't make one, and wants to put it in the record, they can.

[Additional statement submitted for the record follows:]

PREPARED STATEMENT OF HON. KAREN MCCARTHY, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF MISSOURI

Thank you, Chairman Bliley for holding this hearing on H.R. 5122, the Patient Protection Act of 2000. I look forward to the witnesses' testimony on the current state of consumer information regarding medical practitioners and how this legislation will affect both the consumer as well as health professionals.

The National Practitioners Data Bank was created under the Health Care Quality Improvement Act of 1986 because the Congress believed that the increasing occurrence of medical malpractice litigation demanded greater information gathering efforts than any state could undertake. The creation of this Data Bank was expected to augment the traditional forms of credentials review. Currently, information available on the Data Bank is relatively comprehensive, but it not available to the general public. This is problematic for consumers who desire easy access to the professional history of their chosen physician.

In my state of Missouri, consumers do not have access to a medical practitioner's professional history of malpractice suits unless the practitioner has given consent to the licensing board. If a practitioner *has not* given consent, the consumer must hunt through the courthouses to find records of previous lawsuits, at least those conducted in Missouri.

The intent of this bill is laudable. I firmly believe in empowering consumers as they make their decision on a health care provider. I'm concerned that this Committee is moving too quickly on a complex issue. This bill raises concerns about the quality of information to be added to the Data Bank, the interpretation of the data by consumers, and the fairness to medical practitioners of this method of disclosure. This bill requires a significant amount of additional deliberation by the Health and Environment Subcommittee so that major medical groups can share their views to further consumer education an health care decisions.

For these reasons, I withhold my support of H.R. 5122. Thank you Mr. Chairman, and I yield back the balance of my time.

Chairman BLILEY. Now I would like to invite our first panel, if they would come forward and take seats. While they do so, I would ask them when they speak to pull the microphones as close to you as you possibly can because the sound system in this room, though we are supposed to be the high-tech committee, is rather primitive, to say the least.

We will first hear from Mr. Fernandez, and what we like to ask all of our witnesses is we will accept your statement in its entirety. We would like you to summarize in as near 5 minutes as you can. And with that, Mr. Fernandez, the microphone is yours.

STATEMENT OF RUBEN FERNANDEZ

Mr. FERNANDEZ. Thank you. Mr. Chairman and members of the committee, I thank you for the opportunity that you have afforded me today. My name is Ruben Fernandez, and I am the surviving half of a medical nightmare that took the life of my wife Judy in less than 1 day.

I firmly believe if I had been provided access to the National Practitioner Data Bank it would have saved the life of my beloved wife.

I have read the testimony presented on March 1, I have also heard it today, and to put it simply, the negative reactions to opening the National Practitioner Data Bank to the general public is based on fear, myths, professional intimidation and the intentional protection of power by a few in the medical community. Just as in the past, only the elite were able to read and write and the priests were the only ones able to interpret the Bible, today the hospitals and the medical establishment are doing the same by saying that only they can interpret the data.

This country was founded, has prospered and is looked up to by the rest of the world for our stand on freedom, our capability to change the wrongs that have been committed and for our eagerness to share prosperity and good fortune. I suggest that we work together to put another valuable tool in the hands of the consumer by allowing the National Practitioner Data Bank to be accessible by all.

I would like to tell you the story of a girl born and raised in southern California who married, had three children, divorced and remarried to a Cuban immigrant. Together we struggled and fused our dreams, the American dream. We purchased a home, took care of the children and started our own business. Fifteen or so years later the house was paid for, the children were out of the home, the business was doing well, and my wife was now a 40-something woman who had already undergone successful breast augmentation and now was concerned with the extra pounds that she could not easily shed and a couple of new wrinkles on her face. For almost 1 year she researched the available information about the best doctors and finally settled for a plastic surgeon with 20 years of experience, board certified who had actually taught surgery at a medical center. She also checked with the California Medical Board and was told that no problems had been found or reported. Later I found out that this doctor had been successfully sued in another State.

Judy, as many other women, was deceived by aggressive advertisement and salesmanship. By the time she signed the final papers, the "tummy tuck and face peel" that she had wanted turned into "resculpting of the body through liposuction, a mini face lift, a brow lift and a face peel", all at the bargain price of \$20,000 paid in advance.

When I personally questioned the Harvard-trained, Yale-graduate plastic surgeon about the length and number of procedures, he told me, Ruben, don't worry; I have done longer surgeries on 60-year-olds. Still uncertain, I raised my concerns with the anesthesiologist; and his response was, it is long but in the ballpark, and it is safer to do it all at once.

My wife went into surgery at a certified outpatient clinic at about 7:30 a.m. March 17, 1997. Two hours later the records show her blood pressure had deteriorated. The solution was to double the IV fluids. By noon there was little if any urine output, and although the nurse warned the doctor of possible kidney shutdown they overrode her concern and continued to operate. After all, the equipment had been rented and would have to be paid for whether it was used or not.

By the end of the procedures, my wife had received 19 liters of IV fluids in her vascular system and 14 liters of tumescent solution under the skin and remained on the operating table in an irreversible dying condition. By the time the procedure was complete and the doctor faced me, he had the audacity to tell me, Ruben, the operation was a success. Within 3 hours, my wife was pronounced dead at a nearby hospital where this surgeon had privileges.

What followed was a battle against the doctors and lawyers which took almost 2 years, including two trials, one of which lasted over 27 days, where they were finally found to be negligent. To this day, I cannot conceive that the expert witnesses the doctors used were, quote, their peers and included five medical school professors from such institutions as USC, Loma Linda Medical School and Stanford University, all of who testified and tried to convince the judge that what the doctors did was within the standard of care.

By the time the operation was finished, my wife had no blood in her system, had swollen to disfiguring proportions and weighed 33 pounds more than when she went into the operating room. This was all within the standard of care.

Last year we finally had a report by the Institute of Medicine concluding that over 44,000 people die each year due to medical mistakes.

As a society, we were outraged at the Vietnam War where we sacrificed over 50,000 young Americans. I ask of you, how many American lives are we willing to sacrifice for the protection of an elite group? I am in favor and I plead that you allow the National Practitioner Data Bank to be opened to the general public. The consumers have a right to this information, and they need to make an informed decision. After all, most Americans can read and write, they can interpret the Bible or a religious manuscript and also have access to a computer and can learn to interpret complex data.

I ask you to consider the consequences of not making this information available to our citizens.

Thank you for this opportunity, and I am available to answer questions.

[The prepared statement of Ruben Fernandez follows:]

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elite were able to read and write, and the Priests were the only ones able to interpret the bible. Today the hospitals and the medical establishment are doing the same by saying that only they can interpret the data.

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I ask you to consider the consequences of not making this information available to our citizens.

Thank you for this opportunity and I am available to answer any questions you might have about my experience.

Chairman BLILEY. Thank you, Mr. Fernandez.

Mr. Churchill.

STATEMENT OF T.J. CHURCHILL

Mr. CHURCHILL. Mr. Chairman and all committee members, good morning. My name is Tillis James Churchill II. I am a real estate salesperson with Century 21 John Merrill Incorporated in Gainesville, Florida. I am very happy to be here and thankful for being given the chance to make what I hope will be a tremendously positive contribution to the public.

Five years ago my dad, Tillis James Churchill, died after undergoing numerous surgeries performed by Dr. Michael Butler that began as a stomach stapling procedure in which there was a problem with the stapler being misfired. I watched my dad suffer as I have never seen anyone suffer. The nurses wrote that my dad ate a red popsicle, and the popsicle juice leaked out of the incision. My dad suffered hallucinations, adult respiratory distress syndrome and multiorgan failure. My dad's eyes were so swollen in the last hours of his life that he could not even blink. For weeks he suffered with an undetected subhepatic abscess. The problem was that Princeton Hospital did not have diagnostic equipment to accommodate someone of my dad's physical size, and my dad's condition was so deteriorated that he could not be moved to another hospital.

My dad died in Princeton Hospital on his 49th birthday. I miss my dad every day. Our family has gone through much pain as a result of his death. If the National Data Bank's information had been available to my dad, I believe that my dad would still be here. I am here to tell you that it is not fair that vital information in the National Data Bank is being withheld from the public.

My dad always spoke very highly of Dr. Butler. My dad said, Dr. Butler told me he never lost patient. My dad trusted Dr. Butler. He had no reason not to. Only after my dad's death did we find that Dr. Butler had lost at least nine patients and had made 10 malpractice payments. Fortunately, since my dad's death, Florida has made the doctor's claims history public record. However, the disclosure of doctors' past history is still flawed. Consumers also need access to one central source of information at the national level, such as the Data Bank, especially when doctors move from State to State or practice in multiple States.

Supposedly, hospitals are required to check information from the National Practitioner Data Bank every 2 years. While allowing Dr. Butler to practice at the hospital at the time of my dad's death, it has been recently discovered that Princeton Hospital did not check every 2 years. I also do not understand why Princeton Hospital allowed Dr. Butler to perform bariatric surgery in its facility knowing that it lacked an MRI chamber, which could accommodate those persons with large physical stature.

How could this have happened? Where does this leave the public? I feel as though we were thrown to the wolves. Princeton Hospital is no longer in business today. What once was a hospital is now a boarded-up building.

My dad was a schoolteacher and a high school football coach in Gainesville, Florida, for 19 years. He was a very well-respected man in our community. Hundreds of kids have benefited academically and personally with the life lessons he taught in his classes.

I can testify to this because I had my dad as a 7th grade language arts teacher. I grew up being known around town as Mr. Churchill's son. People still tell me today how my dad was the one teacher of which they still have fond memories.

My dad, being the educated man he was, asked Dr. Butler about his background; and Dr. Butler told my dad that he never lost a patient. This is where my dad was deceived. If information in the National Practitioner Data Bank had been available to my dad, I think that my dad and others would still be alive today.

I have viewed a mock-up of what a public access data base might look like. The data base I reviewed was easy to understand and covered the right topics to enable a patient to make an educated and informed consent about the qualification of his physician. A patient always trusts his doctor. Please allow us to trust the right doctor. Thank you all.

Chairman BLILEY. Thank you, Mr. Churchill.

Ms. Hachey.

STATEMENT OF CHRISTINE HACHEY

Ms. HACHEY. Mr. Chairman and members of the committee, thank you for inviting me to appear before you today. My name is Christine Hachey, and I presently work as a travel consultant. My objective is to convince you why the National Practitioner Data Bank should be made public. Let me explain why this is so important to me.

I have always worn glasses to correct nearsightedness and astigmatism. Due to frequent changes in my prescription, I decided to check with another ophthalmologist. At this point it was suggested that I consult with a doctor who also performed RK and AK surgery. After being examined by a technician, I was escorted to the doctor. He then did an extremely cursory exam, took no medical history whatsoever and proceeded to rave about his abilities to correct my vision to a point where I would no longer need corrective lenses for anything except reading. My husband and I made an appointment to participate in one of his seminars to become more informed about the procedure. Again, we were assured that he had done thousands of these procedures with great success.

Upon checking with the Board of Medical Examiners, we were informed that there were no complaints or judgments pending on this doctor. It wasn't until years later that an investigative journalist covering the Data Bank told me that my doctor had multiple settlements. Without this information, we had proceeded to make the appointments and have the surgery. In a span of just 3 months I underwent four surgeries performed by this particular doctor, with my vision becoming increasingly worse each time. At this point, I sought the opinions of four corneal specialists. They all ended up with the same conclusion: My eyes have been irreparably damaged by the surgeries done by the original doctor.

My life has changed drastically. I avoid driving. I restrict my driving to daytime, and never do I drive at night because I don't want to be the cause of an accident. My sight has caused me to be very dependent on others, give up being employed outside of the home, which takes away all benefits enjoyed by regular professionals, and put a strain on all of my everyday tasks. Even the sim-

plest of things such as reading, sewing and painting is done with wearing contacts, glasses and a magnifying glass; and many times extra light is required. I show you that this is the kind of print I would need to have everything in if I wanted to read it without the magnifying glass, and with this, it would take my contacts and my glasses.

Because of this, we have added on to our house so that I would be able to continue to work to some degree but have suffered a tremendous reduction in pay. This has been damaging both emotionally and physically.

This is a situation that could have been prevented. This doctor alone has caused hundreds of people to have a drastic reduction in vision, and this is just one doctor. The public needs to have the ability to research their doctors so they can make informed decisions. This is a preventable epidemic.

The National Practitioner Data Bank would not only help the public sector but it would benefit others such as elected officials, the American Medical Association and insurance companies, just to mention a few.

Elected officials would gain great respect from their constituents by allowing this bill to give each one of us the ability to make informed decisions in situations that can change our lives forever. This would improve our quality of life, offer better health care and help to control medical costs.

The American Medical Association is a highly distinguished group of individuals that service mankind, but there are those who taint this well-deserved reputation. The National Practitioner Data Bank is a major step toward redeeming this lack of credibility and showing commitment to the people. The AMA has suggested that the State boards should analyze how to report the competency of health professionals. This just simply is not enough. Now is the time to help them by making the public more informed. Think of the goodwill and how the public sector would rally behind the AMA if they chose this course.

Not to be forgotten is the insurance sector. They are constantly paying out claims, legal fees and much more. We could all benefit from lower insurance premiums because of fewer damages being paid out on all fronts.

I urge you to look at the mock-up of the NPDB which is on the House Commerce Committee web site. You will be able to realize the user-friendly format that compares doctors in context by specialty and location. The information is there for the public to make their own decision.

You must vote for Chairman Bliley's bill opening the National Practitioner Data Bank so that we can all benefit. Thank you.

Chairman BLILEY. Thank you, Ms. Hachey.

The Chair recognizes himself for 5 minutes.

Mr. Fernandez, despite Dr. Ganske's statement to the contrary, in a Hartford Courant analysis of the Data Bank, Dr. Matory reportedly has 22 entries, including malpractice payments totaling \$1.47 million. I ask you, don't you think this is information that consumers would want to see?

Mr. FERNANDEZ. Definitely. And I would like to emphasize that when my wife checked with the California Medical Board, the in-

formation that Dr. Matory had malpractice in another State was not made part of the California Medical Board records. Therefore, we had no idea that he had damaged other people.

Chairman BLILEY. Would you describe your efforts to notify the medical establishment of this physician's history following your wife's death?

Mr. FERNANDEZ. Well, I was very glad that the truth had finally come out after a long, extensive trial; and I made up two packets that were delivered to two different members of each medical board of every State of the Union. Strictly, the information in there was the findings of the California Medical Board and the decisions to revoke the licenses of the physicians. I sent that out with a certified, signed receipt required by every head of the consumers board of every State. Because I was very keenly, by that time, aware that we do not have a national way of gathering this information; and I did not want that to happen to anyone else; and I wanted each medical board to be accountable for knowing the tragedy that had happened so that another member of their community would not undergo the same problems.

Chairman BLILEY. Thank you.

Ms. Hachey, do you know if your physician is currently practicing?

Ms. HACHEY. Yes, he is practicing. The medical board in Arizona does not show any decisions against him. Matter of fact, he has numerous radio ads. He has TV ads. He has newspaper ads. He is very much in the swing of conducting more surgeries.

Chairman BLILEY. Thank you.

Mr. Churchill, you testified that Dr. Butler lied to your father and told him that he had never lost a patient; and it was not until later that you found that Dr. Butler had lost at least nine patients. Had your father known of Dr. Butler's prior history, would he have sought treatment from this doctor?

Mr. CHURCHILL. Of course not, of course not. There is no way that anyone in their right mind, after having this information presented to them—first of all, I take that back. Anyone in their right mind would have gotten a second opinion.

Chairman BLILEY. Thank you. Do you know if your father's physician is still practicing?

Mr. CHURCHILL. I do not know at this time.

Chairman BLILEY. Okay. Thank you.

Ms. Hachey, in your testimony you mentioned the user-friendly format that our legislation provides for consumers. I know that you have reviewed the mock-up of a report that we have on the Committee on Commerce web site for the public's review. I suggest that other members of the public review the mock-up on our web site as well, which is located at www.house.gov/commerce. Additionally, we have it here in the hearing room today. Can you expound on your opinion of it?

Ms. HACHEY. I can't read that at all, but I did look at the one on the web site.

Chairman BLILEY. It is the same one.

Ms. HACHEY. I found it to be most comforting, because it not only shows you the doctor and his specialty but it compares him with other doctors of the same specialty in the same State. So we are

comparing apples with apples. It goes through and gives you the idea of how many judgments have been against other doctors, and they listed—I think that went up to like five and the percentage of doctors that have had decisions against them. I think that is extremely important because then you get a chance to put him in perspective with—him or her in perspective with other doctors of the same variety.

And then there is no way that this web site is supposed to be saying to me, the public, this is what you ought to do. All they are doing is just giving you the information. You can read it. You can do whatever you want with it. You can dismiss it. You can go to the doctor, you can talk to him and say, well, I saw that you had a suit against you. Would you like to explain to me why? And if he has a suit against him there is no reason why he shouldn't explain it to you.

We all make mistakes, but if you have got a doctor with 25 or more suits against him, I would think that that is trying to tell you something. Because you are going to get into high percentages, and I don't think any of us would want to go to a doctor that had—25 percent of his patients have suffered unnecessary handicaps at his hands.

Chairman BLILEY. Thank you very much.

I see my time has expired. The Chair now recognizes the gentleman from Ohio, Mr. Sawyer.

Mr. SAWYER. I am going to forego questions at this point. I just wanted to take a moment to thank our witnesses for coming forward and telling what must be terribly painful stories in the interest of providing the kind of information from which we can ultimately craft a sound law.

Thank you, Mr. Chairman. I yield back.

Chairman BLILEY. The Chair now recognizes the gentleman from Florida, Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Just very briefly, Mr. Fernandez and Mr. Churchill and Ms. Hachey, I missed the first part of your testimony, too. I apologize. A meeting was called by the chairman in another part of the building, but he left to come here, and the rest of us were stuck in the meeting.

You checked the data on that particular doctor because of the problem—what was it, the injury to your wife?

Mr. FERNANDEZ. Well, no. My wife prior—it was an elective surgery, so she had time, and she had about a year between the time she started till she chose the doctor. She checked with the California board, and that is keenly the issue here. The world has become a much smaller place. You guys keep saying, make it a State issue. It needs to be a national issue, because these doctors are allowed to jump from State to State. And I don't know how Mr. Ganske found out about Dr. Matory's previous lawsuits. He must have another access that we did not. Because when my wife checked with the California Medical Board his records were clear until I hired a private detective is when I—

Mr. BILIRAKIS. But why did—and, again, you may have covered this and forgive me, but why did you all choose to check with the

board on the doctor? Ordinarily, we are referred to a doctor by our family physician or whatever the case may be. We——

Mr. FERNANDEZ. In my wife's case, you know it is elective cosmetic surgery. This guy had plenty of credentials. I mean he has——

Mr. BILIRAKIS. But your wife checked anyhow, even though he had all the credentials.

Mr. FERNANDEZ. Of course, because she was an informed type of person and detailed type of person, if you look at anything she did she was detailed oriented. The critical information was not available. And that is all that we are asking as consumers, is give us the chance to interpret the data and to make our own decisions.

We are not trying to cause harm to the doctors. There are doctors in my family, and we are definitely not trying to cause any harm or any undue distress to the profession. We honor it. We just want to make an informed decision and to be able to make our own choices.

Mr. BILIRAKIS. Very well said.

So, basically, what you are saying, though, is if this were available you feel the public would, in general, on their own, routinely, before they go for some sort of surgery that they would routinely check on the doctor.

Mr. FERNANDEZ. I guarantee you that, yes, especially if the information gets out there. And you know we are becoming a society that depends on quick information, and the Internet is a great access. Thank you.

Mr. BILIRAKIS. Thank you.

Thank you, Mr. Chairman. I yield back.

Chairman BLILEY. The gentleman from New York, Mr. Engel.

Mr. ENGEL. Thank you, Mr. Chairman.

Mr. Fernandez, you remarked in your testimony that you believe that if you had access to the National Practitioner Data Bank that it would have saved the life of your wife. I would like to ask you, what specifically do you believe you would have seen in that that would have altered the decision to use the doctor involved in your wife's surgery? Was it a previous malpractice claim or something else?

Mr. FERNANDEZ. Specifically, later on we found out that he had three payments for malpractice and one lawsuit that was dismissed. That would have given me a heads-up. And as Mr. Ganske here said, he quotes him as being an above average technician and an average doctor by the number of lawsuits. We were in a position where we could have chosen someone else maybe above average. And, actually, the information is all that we are asking for. That is all we need.

Mr. ENGEL. Thank you.

Mr. Churchill, you mentioned that Florida now has a profiling program that is available to the public. If every State had that type of program like Florida and it was linked together so that a doctor could not easily move from State to State, do you think that this would represent a solid approach to the problem, or do you believe that only at the Federal level could this issue be addressed? In other words, could there be an alternate solution to this problem

if every State had a similar program that Florida has and it was linked together so a doctor couldn't move from State to State?

Mr. CHURCHILL. I think I understand your question, but the answer to your question to me seems exactly what the chairman is trying to do here by opening up the National Practitioner Data Bank to the public. The information is already there. So, to me, it is already there. I mean, that is exactly what he is trying to do.

Mr. ENGEL. Okay. Now the hospital in question in the cause of your father's tragic death, you say they didn't query the National Practitioner Data Bank every 2 years as they were required. I am wondering if you or anybody else on the panel would have any suggestions how we could better ensure the hospitals are questioning the NPDB as required.

Mr. CHURCHILL. Sure. Give us the right to check for ourselves, and that way we have the information for our own personal use.

Mr. ENGEL. Would the other two panelists agree with that, or is there anything you would like to add?

Ms. HACHEY. Yes, I would agree. Because there is really no way that we can be assured that the hospitals would be checking it every 2 years, and then we go through another rigmarole with that. If it is out there for us to check and for us to make our own informed decisions, that bypasses a lot of extra checking and extra footprinting on behalf of the medical organization.

Mr. FERNANDEZ. I believe that all we are asking is for the opportunity to use this information on a very, very personal basis from a consumer's standpoint. And I would like to say that later on I did find out that Dr. Matory had actually been pulled from a trauma center where he was practicing because of medical conditions. He apparently had blood pressure problems and diabetes, and that was not known until—and I don't even know if that still known by the system. That is the information that we need because this person got allowed to go into business, set up his practice, hide the true information. Perhaps the day that he practiced on my wife he was having medical problems and he was his own boss and he just proceeded to go ahead and kill her.

Mr. ENGEL. Ms. Hachey, do you believe that the States in themselves cannot properly oversee the practice by disciplining bad doctors? And in your particular instance do you know if your State took any particular action against your doctor and, if so, what it was?

Ms. HACHEY. I don't. I only have experience with the State of Arizona.

Mr. ENGEL. I am sorry, with—

Ms. HACHEY. With the State of Arizona Medical Board. The State of Arizona I think does an exceptionally poor job of handling the affairs. I went to a medical board meeting. I spoke at the medical board meeting. There were 66 complaints against this particular doctor at this one meeting, along with my malpractice suit which I had won in court. And within a 15-minute period of time the medical board waved their magic wand and dismissed all those cases against him and said that they thought he had suffered enough, and that was it.

Now that is one meeting, and I heard of many cases that had taken place prior to this where they had waved their magic wand.

So I don't think that the State medical boards are doing us, the consumer, justice in the way they are carrying out their part of the problem.

Mr. ENGEL. Okay, thank you. Thank you, Mr. Chairman.

Chairman BLILEY. Thank you. Time of the gentleman has expired. Dr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman.

First of all, I want to tell all of you how deeply sympathetic I am to your problems.

Ms. Hachey, losing part of your sight is a terrible thing and especially, it seems, with your type of business where you probably have to deal with fine print on travel forms and things like that.

Mr. Churchill, losing your dad must have been a terrible, terrible loss for you. My dad is ill, has heart problems; and I understand what that would mean.

Mr. Fernandez, to lose your wife, you know your lifelong companion, mother of your children, unexpectedly like that is a terrible thing.

What we are here today to discuss, the Data Bank and opening up the Data Bank, and there are, I think, important questions that will affect whether patients get the type of needed care that they do. For instance, the average obstetrician, OB/GYN, has about 3.2 entries into the Data Bank. About one out of 10 obstetricians today stops practicing obstetrics because of the fear of liability. And I am concerned that if they have a couple of bad babies through no fault of their own or they get a lawsuit that then puts them up above an average, are we then going to see a loss of people being willing to do certain procedures?

Ms. Hachey, did your doctor tell you before the operation that there was a possibility that you could—your sight could be affected, that you could lose part of your sight?

Ms. HACHEY. He told me that the worst I could ever have is what I had right then and there, that it would not get worse and that he would under no circumstances damage my eyes.

Mr. GANSKE. So your consent form specifically did not say that you could lose—that your sight could be worse.

Ms. HACHEY. No, the consent form said that it could be, but the consent form was never gone over with me with the doctor, only with the technician. When I asked the doctor about the consent form, he said, don't worry about it. I have done thousands of these cases. I am not going to hurt you.

Mr. GANSKE. Okay, but your consent form did say that you could lose some vision, and you did sign it.

Ms. HACHEY. Yes, I did.

Mr. GANSKE. Okay. Mr. Churchill, I have operated on patients with morbid obesity. How much did your dad weigh?

Mr. CHURCHILL. Approximately 385 pounds.

Mr. GANSKE. It is a pretty difficult operation sometimes, all the time, and there is a higher incidence of infection and death. As I mentioned previously, there is about a 1 or 2 percent chance of death with that operation in the best of hands.

I did my medical training at the University of Iowa where Dr. Ed Mason was one of the world's acknowledged experts on this,

and I have worked with him. Did his consent form say that there was a possibility he could die from that procedure? Do you know?

Mr. CHURCHILL. I have no idea.

Mr. GANSKE. My point earlier, though, was this that even among the best surgeons, especially those that are doing a lot, over a period of time there could be a number of deaths. Simply being able to look at the numbers of complications may not give you an accurate index if you don't exactly know whether this doctor has just operated on a few or whether he has operated on a great many.

Mr. CHURCHILL. Sure.

Mr. GANSKE. Mr. Fernandez, the Hartford Current article that Chairman Bliley quoted says, but Federal law prohibited Fernandez from discovering what the Current has since learned about Matory's Data Bank file. It showed he settled a malpractice case for \$32,500 3 years earlier in Massachusetts where he had been sued four times.

That is the source of my information. Although the settlement was relatively small, Mr. Fernandez said it would have been enough to have sent his wife to a different doctor. And it does say later in the article that Mr. Matory now, after this episode, has 22 some suits. So it is possible, I would think, that the nature of this case added a considerable number of suits.

I want to say this, though. I have read through the testimony from the California Board of Medical Examiners and from the Attorney General and I agree with their findings and agree with the situation that this physician no longer has a license to practice.

My concern, though, is that at the time that you—before this happened, according to the Current, there were only four entries, only one small settlement, and that that would not have been unusual for a plastic surgeon who has taken care of a lot of complicated cases like he did. So I just want to say I think that you did show a lot of care in choosing a physician, a lot of diligence. I don't think you should ever second-guess yourself on that. Even if the Data Bank had been available, I am not sure that it would have told you that much. But I do want to finish up by saying that, you know, there was a mistake made; and it looks like that physician has been liable for it.

Mr. FERNANDEZ. I thank you for your statement. I can accept a mistake, and I can accept the death of my wife. What I cannot even imagine is the scenario that perhaps this doctor today is out here in Virginia and maybe practicing under some other doctor's license, and we do have a lot of major issues that need to be addressed.

Mr. GANSKE. Thirty seconds.

Chairman BLILEY. Gentleman's time—he has already gone a minute and a half over.

Gentleman from Tennessee, Mr. Bryant.

Mr. BRYANT. Mr. Chairman, I would yield to my colleague from Iowa to follow up on that.

Mr. GANSKE. Thank you.

I agree with this panel in that there should be better communication between the State boards on medical registration, and it may be very well that the Federal Government could do something to facilitate the technology and the ability to get the data to the various State boards of registration.

Thank you. I yield back.

Mr. BRYANT. With that said, I am like others that are at the end of the questioning. I think a lot of questions have already been asked to you. I, too, want to thank you. I was late to the meeting.

I have read your testimony. Ms. Hachey, I have read the end of yours; and certainly I will renew my compliments to our chairman for holding this hearing and bringing out certainly your testimony which is very enlightening to this progress of this bill. I look forward to the other panels and their testimony, and as we get the big picture we want to assure you that we do what we think is best in this situation. Again, we appreciate your forthrightness in coming here; and we also express our sorrow for the tragedies that you have had.

Thank you.

Mr. FERNANDEZ. Thank you, and I would like to say something. If we could put a man 20, 30 years ago on the Moon—I can certainly say that with such highly qualified people we could make the law and change things just so that we do have a better, clearer picture of what is going on. Let's not put politics into it. Let's look at a problem and solve it. That is all I am asking as a consumer.

Thank you so much.

Chairman BLILEY. The gentleman from Illinois, Mr. Shimkus.

Mr. SHIMKUS. Thank you, Mr. Chairman. I also appreciate the testimony, and I have no questions, so I yield back.

Chairman BLILEY. I thank the panel. You have been very helpful. We will now excuse you and move on to the second panel.

I thank the members of the panel. I apologize again for your delay in getting on. I hope we haven't unduly disrupted your travel plans as you attempt to return to your community.

First, we will hear from Mr. Charles Inlander, President of the People's Medical Society from Allentown, Pennsylvania.

Once again, I would ask the panel to, when you testify, to pull the microphone as close to you as you possibly can because the acoustics and the system—it is terrible.

STATEMENTS OF CHARLES B. INLANDER, PRESIDENT, PEOPLE'S MEDICAL SOCIETY, ACCOMPANIED BY MICHAEL A. DONIO, DIRECTOR OF PROJECTS; JAMES B. STEWART, AUTHOR; TRAVIS B. PLUNKETT, LEGISLATIVE DIRECTOR, CONSUMER FEDERATION OF AMERICA; RICHARD F. CORLIN, PRESIDENT ELECT, AMERICAN MEDICAL ASSOCIATION; RODNEY F. HOCHMAN, CHIEF MEDICAL OFFICER, SENTARA HEALTHCARE, ON BEHALF OF AMERICAN HOSPITAL ASSOCIATION; EDWARD A. LONIEWSKI, ON BEHALF OF AMERICAN OSTEOPATHIC ASSOCIATION; AND RACHEL WEINTRAUB, STAFF ATTORNEY, U.S. PUBLIC INTEREST RESEARCH GROUP

Mr. INLANDER. Thank you very much, Mr. Chairman.

I am Charles Inlander from the People's Medical Society, and it is a pleasure to be back here 14 and 15 years later from the last time we were here to talk about this very issue of opening the Data Bank to the public.

Mr. Chairman, we strongly support the legislation that you have introduced, the Patient Protection Act of 2000. I must say we are

astounded by what we heard said this morning in the opening statements by most of the members with respect to the issue of forgetting about the consumer and worrying about the trade associations that are here to represent the various interests that are before this panel today.

This is an issue about consumers. It is not a new issue. Every consumer organization in the United States has felt for the last 14 years that illegally and probably with great surreptitiousness the Congress of the United States has failed to give us the right to access information that we, the taxpayers, are not only paying for but, in essence—we are, in essence, granting the licenses to these practitioners to practice.

The fact is that it is important to remember that all medical practitioners covered by the law that created the National Practitioner Data Bank are licensed by individual States. But it is too often forgotten that a license to practice medicine is a privilege, not a right; and that privilege is granted by the citizens of this country through the government that we have duly elected. In other words, we, the public, grant physicians and medical professionals their licenses. Our Federal and State governments serve as the conduits for the granting of those licenses.

Should we not then have the right to know when a licensed practitioner has performed an act by commission or omission that might violate the terms of that license or the right to know when a licensed practitioner has been found guilty or settled a malpractice suit, the right to know when a licensed practitioner has had privileges revoked or suspended by a hospital that has also been granted a license by the State? To those of us in the public the answer is clearly, yes, we have the right to know and should have the right to know.

It is also too often forgotten that medical licenses exist to protect the public, not the practitioners. Licensing came about at the urging of legitimate medical entities and public demand to ensure the public that the practitioners they use might utilize and have met the best educational, character and experience requirements; and those requirements were established for patient safety reasons, not professional sovereignty reasons.

Patient safety, however, with regard to medical practitioners is not assured simply because a license is granted. Since States require a physician to pass a licensing examination only once, the ongoing career activities of practitioners are generally not monitored on a routine basis by State medical licensing boards or any other government entity. Unless a complaint is filed by a consumer, another medical professional or a medical facility, a physician is essentially unwatched and unmonitored throughout his or her career. Yet even when an action is taken against a practitioner by a State board or a hospital or a court, it is rarely reported publicly, if at all.

Most medical malpractice suits are settled with secrecy clauses attached, effectively shielding the practitioner from public view. Most actions taken by State licensing boards are published in obscure publications generally not easily accessible to the public.

As an example, a physician could be in an alcohol rehab program at the urging of a State licensing board and still be allowed to prac-

tice medicine and not have to disclose that to the patients they serve. Yet Dwight Gooden couldn't throw a baseball at a man wearing a helmet because he has violated his own service—with the violation of a drug problem.

Yet few, if any, hospitals ever publicly announce the practitioners have been suspended or revoked. In other words, the public, the people who are most served by knowing the good and the bad about their practitioners are essentially kept in the dark by the quality of the medical professionals who serve us. Let me illustrate the point.

As recently as last year, we could find only one State that provided a toll-free telephone number for its State medical licensing board; and no State published the phone number of the board in any location other than the State capital. How are we supposed to find out what a doctor did? The State of New York gives you an 800 number to file a complaint, but you have to pay to get information about complaints filed if you want to find out anything beyond that.

Several years ago, I appeared on a national television program with a group of women who had won sizable medical malpractice judgments against a physician. In fact, the doctor had been found guilty of or settled a total of 32 malpractice suits. In addition, the doctor had just been released from prison after serving a 2-year sentence for a failure to pay child support. He was licensed in five different States, yet none had taken any action against him. Only after our appearance on the show did the boards take action, yet each of the 32 women who had been maimed by this doctor said that if they had known his record not one of them would have agreed to use him for treatment.

We are sure his record was in the Data Bank. We don't know for sure because we can't see the Data Bank. And, by the way, there is not a member of this committee who can sit and say with impunity that they know what is in the Data Bank because you don't have the right to see what is in that Data Bank; and to have statements made this morning that that information isn't good is absolutely absurd because no one on this committee legally has been able to see what is in the Data Bank, just like us.

Ironically, the National Practitioner Data Bank was born because States were routinely and unknowingly granting licenses to practitioners who had either lost a license to practice in another State or were on the brink of losing their license. Too many physicians would routinely run from State to State where they had not lost a settlement or before a major malpractice action was taken.

The point is, Mr. Chairman, and I think in concluding, that we as consumers should have the right to access the National Practitioner Data Bank; and all the objections that were raised by many of the parties that are at this table right now 14 and 15 years ago have borne out to be not true. When we look at Massachusetts' experiences, when we hear about many other States, doctors did not flee the State. Bad doctors are possibly identified, but the consumer can make that choice. And I think the bottom line is, sir, we are not medical idiots. We are able to make rational and reasonable decisions when we look at information. Thank you.

[The prepared statement of Charles B. Inlander follows:]

PREPARED STATEMENT OF CHARLES B. INLANDER, PRESIDENT, PEOPLE'S MEDICAL SOCIETY

Mr. Chairman and Members of the Committee: On behalf of the People's Medical Society, we are pleased to appear before you today, to speak in support of H.R. 5122, *The Patient Protection Act of 2000*. Prior to and since the passage of the legislation that created the National Practitioner Data Bank, the People's Medical Society has been a consistent voice in behalf of the nation's health care consumers, calling for the public opening of the important and valuable data now stored in it. We believe it is in the public interest that not only the Data Bank be unlocked, but also that consumers should have a legal right to any information the government collects about licensed medical professionals. Such information is essential for an individual to make an informed decision about the practitioners he or she chooses to use. Such information may mean the difference between life and death.

It is important to remember that all of the medical practitioners covered by the law that created the National Practitioner Data Bank are licensed by the individual states. But it is too often forgotten that a license to practice medicine is a privilege, not a right. And that privilege is granted by the citizens of this country through the government that we have duly elected. In other words, we the public grant physicians and other medical professionals their licenses. Our federal and state governments serve as the conduits for the granting of those licenses. Should we not, then, have the right to know when a licensed practitioner has performed an act by commission or omission that might violate the terms of that license? The right to know when a licensed practitioner has been found guilty or settled a medical malpractice suit? The right to know when a licensed practitioner has had privileges revoked or suspended by a hospital that has also been granted a license to serve by the state? To those of us in the public, the answer is clearly yes.

It is also too often forgotten that medical licenses exist to protect the public, not the practitioners. Licensing came about, at the urging of legitimate medical entities and public demand, to assure the public that the practitioners they might utilize have met educational, character and experience requirements. And those requirements were established for patient safety reasons, not professional sovereignty reasons.

Patient safety, however, with regard to medical practitioners is not assured simply because a license is granted. Since states require a physician to pass a licensing examination only once, the ongoing career activities of practitioners are generally not monitored on a routine basis by state medical licensing boards or any other government entity. Unless a complaint is filed by a consumer, another medical professional or a medical facility, a physician is essentially unwatched and unmonitored throughout his or her career.

Yet even when an action is taken against a practitioner by a state board or hospital or by a court, it is rarely reported publicly, if at all. Most medical malpractice suits are settled with secrecy clauses attached, effectively shielding the practitioner from public review. Most actions taken by state licensing boards are published in obscure publications generally not easily accessible to the public. And few if any hospitals will ever publicly announce that a practitioner's privileges have been suspended or revoked. In other words, the public, the people who are most served by knowing the good and bad about their practitioners, are essentially kept in the dark about the quality of the medical professionals who serve us.

To illustrate our point, let me relate the following: As recently as last year, we could find only one state that provided a toll-free telephone number for its state medical licensing board. And no state published the phone number of the board in any location other than the state capitol.

Several years ago I appeared on a national television program with a group of women who had won sizeable medical malpractice judgments against a physician. In fact, the doctor had been found guilty of or settled a total of 32 malpractice suits. In addition, the doctor had just been released from prison after serving a two-year sentence for failure to pay child support. He was licensed in 5 different states, yet none had taken action against him. Only after our appearance on the show did the boards take action. Yet each of the 32 women who had been maimed by this doctor said that if they had known his record, not one of them would have agreed to use him for treatment. We are sure his record was in the Data Bank.

Ironically, the National Practitioner Data Bank was born because states were routinely and unknowingly granting licenses to practitioners who had either lost a license to practice in another state or were on the brink of losing their license. Too many physicians would routinely run from a state where they had lost or settled a major malpractice action and set up practice in another state. Congress, responding to the rising voice of public outrage over these practices, responded by creating

the National Practitioner Data Bank. But in doing so, and with all due respect to this Committee, Congress made a major mistake. Instead of truly protecting the interests of the public by making the Data Bank open to the public, Congress weakened the legislation by locking up the gathered information and hiding the key from the American public. In so doing, our legislators were clearly responding to the professional and self-serving interests of the medical trade associations.

As we mentioned earlier, we strongly support H.R. 5122. The information it will make public is the type of vital information every health care consumer needs to make an informed decision. It is obviously not everything we need to know, but nonetheless it is important data.

Ever since the original draft of the original bill that created the Data Bank, strong and adamant voices in the medical community have opposed making public the information contained in the Data Bank. These voices, primarily articulated through the trade associations representing hospitals and practitioners, have argued that practitioners may be unjustifiably slandered by innuendo or misunderstood data. They have said many physicians would leave their practices, only take easy cases or deny care to patients they feel might be a risk to sue or pursue action.

It is important to answer those assertions. First, the most important point to remember about the information contained in the Data Bank is that it does not include charges made against a practitioner. Rather, the Data Bank contains only actions taken against a doctor by a recognized entity: a state licensing board, a court, a hospital or the federal agency. How can such an action be misinterpreted?

Further, there is no evidence that publicly disclosing actions taken against doctors will in any way negatively affect the care delivered to patients. Opponents of full disclosure claim that surgeons, who perform high-risk procedures, will simply stop seeing patients. This is untrue. The experience in Massachusetts, which initiated a physician background and disclosure program about four years ago, proves otherwise. There has been no mass exodus of physicians from the Commonwealth. Furthermore, the Massachusetts Medical Society was involved in the writing of the bill that brought about the physician profile program. To date, this has been one of the most successful disclosure programs implemented in any of the 50 states. We believe that when the National Practitioner Data Bank is opened, we will see the same results on the national level.

We do not envision, nor do we believe, that passage of H.R. 5122 will unleash a witch hunt against good and honest physicians. H.R. 5122 is not a vendetta against the medical profession. Nor do any responsible consumer organizations who support the legislation wish to wage any vendetta. Rather, we seek to put in full view the previously hidden information concerning actions against physicians and permit an informed consumer to make a decision on whether to establish a professional relationship with a physician.

We support the strong safeguards for both physicians and consumers found in H.R. 5122 including confidentiality of patient identity and no listing of a physician's home address, Social Security number or DEA number. We also support the right of physicians to add any relevant statements to their profiles that clarify any of the entries or provide more information to the consumer.

Information relating to medical malpractice settlements should be presented in such a manner that consumers will be able to determine how often physicians in specific specialties are subjects of litigation. Comparisons of a physician's record to all physicians in his or her specialty provide the type of information required by consumers. This also enables consumers to discuss their concerns directly with the physician in question.

Opening the National Practitioner Data Bank to the public will not only empower the health care consumer, but it will improve the medical profession as well. Good practitioners will shine. Other practitioners will do better, working harder to improve so that they can effectively compete for patients and professional privileges.

Therefore, we strongly support the passage of H.R. 5122 and urge the members of this Committee and all the other members of the House of Representatives to honor and respect the intelligence of their own constituency by giving them the tools and information they need to make an informed and valid health care decision.

Chairman BLILEY. Thank you.

The next witness is Mr. James Stewart, author of *Blind Eye: How the Medical Establishment Let a Doctor Get away With Murder*. Mr. Stewart.

STATEMENT OF JAMES B. STEWART

Mr. STEWART. Thank you, Mr. Chairman, members of the committee.

In over 20 years as a reporter and editor I have never encountered a story more extraordinary than that of Michael Swango, a physician who used his medical training and skills in pursuit of a career as a serial killer. Earlier this month, Swango pleaded guilty to five felonies and admitted murdering four of his patients through lethal injection and attempting to kill four more. I believe as we sit here today he has pleaded guilty to murder in Ohio as well.

He is suspected of murdering scores of patients in a medical career that spanned over 15 years and took him from Illinois to Ohio, to Virginia, to South Dakota, to New York and then to Zimbabwe in southern Africa. Swango was en route to yet another job at a hospital in Saudi Arabia when he was arrested at O'Hare Airport in 1997.

It is not my purpose today to dwell on Swango's hair-raising saga, which is told in my book, *Blind Eye*, published last year by Simon & Schuster. Rather, I would like to underscore those aspects of his story which touch directly on the effectiveness of the National Practitioner Data Bank and which point to the urgent need for reform. Lives can be saved by this Congress. Future Swangos need never again terrorize unsuspecting patients.

The simple fact is that the NPDB did not prevent Swango from being hired and from killing patients, including instances where doctors who hired him knew he had been convicted of poisoning people in Illinois. They never checked with authorities in Illinois nor did they contact the Data Bank. I can't imagine a more glaring failure of systems meant to protect the public from incompetent, impaired and criminal physicians, not to mention serial killers like Swango. How could a felon, a convicted prisoner be entrusted with patient care?

As *Blind Eye* makes clear, there is no simple answer, but many authorities were grossly negligent. Once Swango was hired and came under suspicion, fear of litigation, scandal and potential liability often seemed more important to other doctors and hospital officials than patient safety. A fraternity of doctors often rallied around Swango, forming a "white wall of silence" that makes the police's "blue wall" seem porous by comparison.

The culture of the medical profession will not change because of one case, though I believe efforts are being made by many well-intentioned doctors. Nor will it change through legislative fiat. But legislative remedies to protect the public seem relatively simple.

Congress through the Health Care Quality Improvement Act of 1986 established the National Practitioner Data Bank to prevent the likes of a Swango from moving from hospital to hospital. It was introduced by then Congressman Ron Wyden, passed both Houses unanimously and was signed into law by President Reagan. It is an excellent example of bipartisan cooperation in the public interest.

In theory and in legislative intent, it should have prevented someone like Swango from practicing medicine. Yet Swango was

hired in South Dakota in 1992 and New York in 1993, several years after the Data Bank went into service.

At no point in the application review and admission process did it seem to occur to anyone to check whether the NPDB had anything on Swango. It is doubtful the Data Bank would have had anything on Swango, even had they called, since criminal convictions aren't required to be reported. As South Dakota concluded in 1992 after an internal investigation into Swango's hiring, "apparently there is no medical clearinghouse for information concerning criminal charges such as these."

As a result, in *Blind Eye* I proposed that criminal convictions be reported to the Data Bank and that information in the Data Bank be made available to the general public. To me these seemed relatively modest amendments to existing legislation. It didn't occur to me that they would trigger any opposition, even though I was mindful that the AMA had opposed creation of the data base in the first place. Perhaps I was naive.

Let me be clear that I bear no animosity toward organized medicine or individual doctors; and, on the contrary, I have tremendous admiration for many doctors and other members of health care professions. Since *Blind Eye* was published, I have heard from many doctors who care deeply about patient welfare, security and trust, and enthusiastically support calls for reform.

But since my book appeared, the AMA has argued that the Swango story is irrelevant to the efficacy of the NPDB because he is a psychopath, quote, not a physician who made a negligent mistake, unquote, and that his poison conviction and license revocations occurred before the Data Bank went into operation. This is disingenuous. The disconcerting fact is that Swango is a psychopath and a physician. If a serial killer can slip through the cracks, who else has?

He was admitted to practice in American hospitals on two occasions while the Data Bank was in operation, yet no one thought to check with the NPDB. Moreover, even if this poison conviction had occurred more recently, it apparently wouldn't have appeared in the Data Bank. Nor is it clear that his guilty pleas to multiple murders this month would show up in the Data Bank under the law as it now exists.

Finally, what is important now is not whether Swango was or was not in the Data Bank; it is whether future Swangos will be. More generally, the AMA has argued that the public might misinterpret information contained in the NPDB. Yet in the Swango case I cannot imagine that any patient would have any difficulty understanding that a physician had been convicting of poisoning people. On the contrary, it is other doctors and hospital officials who seem to have had difficulty grasping the significance of this fact.

To cite one example, an official who hired Swango as an emergency room physician in Ohio testified as a character witness for Swango at his sentencing hearing. This extraordinary dialog taken from the court transcript ensued:

The prosecutor: What I am getting at is that you as an employer of doctors wouldn't be bothered by the fact that the doctor had been charged with six counts of poisoning?

We were concerned about it, sure, the official answered.

And even though he has been convicted you would rehire him?

Yes, the official said. Based on what he did for the company, the patients that he treated, if it were up to me, I would.

It is my belief the proposed legislation under consideration by this committee, the Patient Protection Act, would go a long way to addressing the serious problems illustrated by the Swango case. I hope it will attract wide bipartisan support. Criminal convictions need to be included. If doctors and hospitals don't query the Data Bank or fail to act on the information, then the public must have access to the information to protect itself.

Swango is obviously an extreme aberration.

Chairman BLILEY. Mr. Stewart, would you summarize, please?

Mr. STEWART. Yes, I am about to conclude.

It would be comforting but foolish to assume that no other physicians will ever seek deliberately to harm or kill their patients.

As Members of Congress you have the opportunity to make sure that future Swangos as well as less egregious but still life-threatening offenders never find their way into the nation's hospitals.

Thank you.

[The prepared statement of James B. Stewart follows:]

PREPARED STATEMENT OF JAMES B. STEWART

In over 20 years as a reporter and editor I have never encountered a story more extraordinary than that of Michael Swango, a physician who used his medical training and skills in pursuit of a career as a serial killer. Earlier this month Swango pleaded guilty to five felonies, and admitted murdering four of his patients through lethal injection and attempting to kill four more. He is suspected of murdering scores of patients in a medical career that spanned over 15 years and took him from Illinois, to Ohio, to Virginia, to South Dakota, to New York and then to Zimbabwe in southern Africa. Swango was en route to yet another job at a hospital in Saudi Arabia when he was arrested at O'Hare Airport in 1997.

It is not my purpose today to dwell on Swango's hair-raising saga, which is told in detail in my book, "Blind Eye," published last year by Simon & Schuster. With Swango's recent guilty plea and sentencing to three consecutive life prison terms without possibility of parole, his medical career has mercifully been brought to an end. Rather, I would like to underscore those aspects of his story which touch directly on the effectiveness of the National Practitioner Data Bank and which point to the urgent need for reform. Lives can be saved by this Congress. Future Swangos need never again terrorize unsuspecting patients.

Three years ago, when I was first alerted to Swango's career by Dennis Cashman, a judge in Quincy, Illinois, I reacted with disbelief. It seemed inconceivable that Swango had been able to pursue a career as a hospital physician even after being convicted in 1985 of the non-fatal poisoning by arsenic of several paramedics. Judge Cashman had presided at Swango's trial and sentenced him to the maximum five-year term. He assumed he had ended Swango's career as a doctor. Yet after Swango was released from prison, Cashman received periodic calls from medical programs on the brink of hiring Swango. Sometimes the calls came after Swango had already been hired. Although Cashman contacted the American Medical Association, his efforts had obviously failed to stop Swango.

When I delved into the Swango case in the course of over two years of research, the facts turned out to be even more shocking. Even before his poisoning conviction, Swango had been investigated for murder while a resident at the Ohio State University hospitals in Columbus. Swango was accused by eye-witnesses of injecting a patient with a paralyzing drug, and the death rate soared among his patients during his tenure. Swango has now admitted murdering one of those patients, a young gymnast injured in a car accident, and attempting to kill the woman whom he injected with the paralyzing drug. Yet at the time, doctors chose to believe Swango's inconsistent explanations over the testimony of nurses and patients, and returned Swango to patient care after a cursory investigation that officially exonerated him. Doctors (two of whom had participated in the investigation) subsequently wrote glowing recommendations that he be licensed to practice medicine in Ohio, and he

was licensed. Nonetheless, the university terminated his residency after his one-year internship.

Seven years later, after his conviction and prison term in Illinois, Swango applied to the residency program at the University of South Dakota. Medical school doctors admitted him and entrusted him with patient care even after Swango told them he had been convicted of poisoning co-workers. They believed him when he told them the conviction was a miscarriage of justice. Doctors never checked Swango's allegations with officials in Illinois, where the case was a matter of public record. They did contact Ohio State, which said nothing about the earlier murder investigation or why it had terminated his residency.

When Swango's past was uncovered and he was dismissed by the University of South Dakota, he applied to a residency program at the State University of New York at Stony Brook. There he was accepted by a committee of three psychiatrists who believed his false claim that his felony conviction stemmed from a "bar room brawl." Again, no one checked his story, even though he was an admitted felon. Swango has now pleaded guilty to three murders during his tenure at a hospital on Long Island.

From there, Swango moved to the Atlanta area and then to Africa, where he was again hired as a physician and the death toll mounted.

I can't imagine a more glaring failure of systems meant to protect the public from incompetent, impaired, and criminal physicians—not to mention serial killers like Swango. How could a felon, a convicted poisoner, be entrusted with patient care?

As "Blind Eye" makes clear, there is no simple answer. Admitting authorities were grossly negligent. Once Swango was hired and came under suspicion, fear of litigation, scandal and potential liability often seemed more important to other doctors and hospital officials than patient safety. A fraternity of doctors often rallied around Swango, forming a "white wall of silence" that makes the police "blue wall" seem porous by comparison.

The culture of the medical profession will not change because of one case, though I believe efforts are being made by many well-intentioned doctors. Nor will it change through legislative fiat. But legislative remedies to protect the public seem relatively simple.

Congress, through the Health Care Quality Improvement Act of 1986, established the National Practitioner Data Bank (NPDB) to prevent the likes of a Swango from moving from hospital to hospital. It was introduced by then-Congressman Ron Wyden, passed both houses unanimously and was signed into law by President Reagan despite opposition from the American Medical Association and American Hospital Association. It is an excellent example of bipartisan cooperation in the public interest. As Wyden wrote at the time in *The Washington Post*, "the need for legislation is clear. There is no effective national system for keeping tabs on doctors who are truly incompetent."

The NPDB went into operation in 1990. Under the law, hospitals are required to report certain disciplinary actions to the data bank and to check with it before granting hospital privileges. In theory, and in legislative intent, it should have prevented someone like Swango from practicing medicine. Yet Swango was hired in South Dakota in 1992, and in New York in 1993, several years after the data bank went into service.

At no point in the application review and admission process did it seem to occur to anyone to check whether the NPDB had anything on Swango. As the act has been interpreted, interns and residents fall into a gray area: hospitals can query the data bank before hiring residents, but they aren't required to. Only licensed physicians must be queried.

It's doubtful the data bank would have had anything on Swango even had they called. When I asked an official at the data bank, I was told that its contents were strictly confidential, available only to doctors and hospital officials, so I can't be sure. Swango's license suspensions by Illinois and Ohio occurred before the data bank went into service. More fundamentally, criminal convictions aren't required to be reported. As South Dakota concluded in 1992 after an internal investigation into Swango's hiring, "Apparently, there is no medical clearing house for information concerning criminal charges such as these."

Swango thus appears to have slipped through several glaring loopholes: he was a medical resident and M.D., not a "licensed" doctor; his crimes would not have been included in the data bank in any event; and even if he was in the data bank, his prospective patients would never have had access to that information.

As a result, in "Blind Eye" I proposed that the data bank's coverage be extended to all physicians, whether "licensed" or not; that criminal convictions be reported; and that information in the data bank be made available to the general public. To me these seemed relatively modest amendments to existing legislation. It didn't

occur to me that they would trigger any opposition, even though I was mindful that the AMA had opposed the creation of the data bank in the first place. Perhaps I was naive.

Let me be clear that I bear no animosity towards organized medicine or individual doctors, and on the contrary, I have tremendous admiration for many doctors and other members of the health care professions. Since "Blind Eye" was published I have heard from many doctors who care deeply about patient welfare, security and trust, and have enthusiastically supported calls for reform. The AMA itself deserves some credit in the Swango story. An AMA official did check with Illinois authorities when Swango audaciously applied for membership in 1992, and another official tipped the dean of the University of South Dakota Medical School to Swango's presence there. Regrettably, the AMA took no systematic steps to prevent Swango from being hired elsewhere.

Since my book appeared, the AMA has argued that the Swango story is irrelevant to the efficacy of the NPDB because he is a psychopath, "not a physician who made a negligent mistake," and that his poison conviction and license revocations occurred before the data bank went into operation. This is disingenuous. The disconcerting fact is that Swango is a psychopath AND a physician. If a serial killer can slip through the cracks, who else has? He was admitted to practice in American hospitals on two occasions while the data bank was in operation, yet no one thought to check with the NPDB. Moreover, even if his poisoning conviction had occurred more recently, it apparently wouldn't have appeared in the data bank. Nor is it clear that his guilty pleas to multiple murders this month would show up in the data bank under the law as it now exists. Finally, what is important now is not whether Swango was or was not in the data bank. It is whether future Swangos will be.

More generally, the AMA has argued that the public might misinterpret information contained in the NPDB. Yet in the Swango case, I cannot imagine that any patient would have any difficulty understanding that a physician had been convicted of poisoning people. On the contrary, it is other doctors and hospital officials who seem to have had difficulty grasping the significance of this fact. To cite one example, an official who hired Swango as an emergency room physician in Ohio testified as a character witness for Swango at his sentencing hearing. This extraordinary dialogue, taken from the court transcript, ensued:

The prosecutor: "What I'm getting at is that you as an employer of doctors wouldn't be bothered by the fact that the doctor had been charged with six counts of poisoning?"

"We were concerned about it, sure," the official answered.

"And even though he has been convicted, you would rehire him?"

"Yes," the official said. "Based on what he did for [the] company, the patients that he treated, if it were up to me, I would."

It is my belief that proposed legislation under consideration by this committee, the Patient Protection Act, would go a long way to addressing the serious problems illustrated by the Swango case. I hope it will attract wide bipartisan support. I recognize that the requirements of the existing legislation and these proposed reforms impose some burdens on doctors and hospitals. But doctors are accorded unique positions of respect, trust and responsibility. Patients' lives hang in the balance.

Swango is obviously an extreme aberration. It would be comforting but foolish to assume that no other physicians will ever seek deliberately to harm or kill their patients. Unfortunately, data show that serial killings in general, and in hospitals in particular, have increased exponentially in this country since 1970.

As members of Congress, you have the opportunity to make sure that future Swangos, as well as less egregious but still life-threatening offenders, never find their way into the nation's hospitals.

Chairman BLILEY. Thank you.

Now, we will hear from Mr. Travis Plunkett, Legislative Director, Consumer Federation of America. Mr. Plunkett.

STATEMENT OF TRAVIS B. PLUNKETT

Mr. PLUNKETT. Good afternoon, Mr. Chairman; and thank you very much for holding this hearing on this extremely important bill. My name is Travis Plunkett, and I am Legislative Director of the Consumer Federation of America. I appreciate the opportunity to offer my comments today on this legislation on behalf of the Consumer Federation and two other national organizations, Con-

sumers Union, the publisher of Consumer Reports, and the Center for Medical Consumers.

There is a very simple reason why the entire consumer community is united in strong support of opening up the National Practitioner Data Bank to the public. This taxpayer-supported data base provides crucial information that consumers can use in conjunction with other sources of information, where available, to choose the right physician and protect themselves from dangerous providers.

Selecting a physician or a physician network is a daunting task for consumers in today's managed care environment. Choosing a provider is made even more difficult because most consumers must make this decision with very little information, as you have heard, about a provider's competency. Concern about medical errors has never been greater. Hospital and insurers have relied on the Data Bank to make important decisions about physicians for a decade—in fact, are required to, as you have heard, by Federal law in some cases to rely on the Data Bank. So why shouldn't consumers?

As you have already heard a great deal about why this bill is good for consumers, I would like to respond to some concerns that have been raised by organizations opposed to this legislation. Some have suggested, for instance, that consumers cannot understand the limitations of information available in the National Practitioner Data Bank, particularly regarding medical malpractice payments. Ignoring the fact that this bill requires that consumers be presented with fair and clear contextual information about malpractice payments, these opponents express the concern that consumers will misuse the information and jump to inaccurate and unfair conclusions, for instance, about providers who have not committed malpractice but who have settled a claim just to avoid an expensive court battle.

Fairness to a provider is very important, but sadly we in the consumer community have repeatedly heard this rather patronizing line of thought before. I will charitably call it the "ignorant consumer" argument. I first heard it in New York in 1986 regarding a proposal to provide maternity patients with data about how often certain procedures such as Cesarean sections were performed at hospitals, and then again a few years later when New York disclosed risk-adjusted cardiac surgery data on a hospital-by-hospital basis. The sky didn't fall in New York. Consumers and other purchasers did not misuse the information. They are better informed and better able to make purchasing and health care decisions. That is exactly what this bill will allow.

Most people are perfectly capable of understanding the limitations of information that is provided to them. Consumers make similar distinctions every day regarding their health care choices. Moreover, the question of how consumers will use or misuse information of this sort is no longer an academic one. Thanks to the Commonwealth of Massachusetts and a few other States, we have real experience with what happens to this information when it is provided to the public.

As you have heard and will hear, the Massachusetts medical board reports that none of the fears that were initially expressed about misuse of this information have been realized. The profiles are wildly popular in Massachusetts with consumers, and in focus

groups consumers made it very clear that they would not find the profiles credible and valid without malpractice information.

Let me note with respect, Chairman Bliley, that you and your staff have bent over backwards to ensure that consumers will understand the limitations of this information. The bill mandates a total of nine different disclaimers or pieces of contextual information about the data that consumers will see; and, frankly, I have to say nine is pushing it a bit, from my perspective. At a certain point, if your goal is for people to use the information, you have just got to give it to them, tell them what they need to know about it and get out of the way. Otherwise, they won't use it.

Now, the next point of opposition, having worked at the State level for many years, I was absolutely stunned to see the AMA telling Congress that they support this type of disclosure but that it is better to leave this disclosure to the States. This is almost funny to me. At the State level, it is often the very same doctors who oppose or resist public access. Unfortunately, I fear that the Massachusetts Medical Society is the enlightened exception here.

Let me give you a very concrete and current example. At the very same time, right now, that the AMA is telling you the States should provide this type of public disclosure, a physician profile bill that passed by overwhelming bipartisan margins and received the support of major business and consumer groups sits on the desk of the Governor of New York, and the New York State Medical Society is urging him to veto it, and this is 4 years after the Massachusetts law took effect.

Of course, consumer access to the Data Bank is no substitute for effective State disclosure, oversight and physician discipline. It is a supplement to these efforts, and we think that point has been made very clearly before.

Finally, we all agree that the data in the Data Bank is imperfect. It is, however, at this point the best available information we have. Hospitals and insurers rely on it. It can and should be improved, but this should not be used as an excuse to delay access to consumers.

Thank you very much.

[The prepared statement of Travis B. Plunkett follows:]

PREPARED STATEMENT OF TRAVIS B. PLUNKETT, LEGISLATIVE DIRECTOR, CONSUMER FEDERATION OF AMERICA ON BEHALF OF THE CENTER FOR MEDICAL CONSUMERS, CONSUMER FEDERATION OF AMERICA AND CONSUMERS UNION

Good morning. My name is Travis Plunkett and I am the legislative director of the Consumer Federation of America.¹ I appreciate the opportunity to offer my comments today in strong support of H.R. 5122, which would allow the American public access to information in the National Practitioner Data Bank about physicians' licensure, disciplinary and medical malpractice history. I also offer this testimony on

¹ The Consumer Federation of America is a non-profit association of more than 250 organizations which, since 1968, has sought to advance the consumer interest through advocacy and education.

behalf of two other national organizations, Consumers Union² and the Center for Medical Consumers.³

I would like to commend Chairman Bliley for introducing this important legislation, and Congressmen Dingell, Upton and Stupak for the significant work that they have done in thoroughly evaluating the potential consequences of such a move. The comprehensive and balanced hearings that have been held by the Commerce Committee's Subcommittee on Oversight and Investigations on this issue have set the stage for timely passage of H.R. 5122.

There is a very simple reason why the consumer community is united in support of opening up the National Practitioner Data Bank to the public. This taxpayer-financed database provides crucial information that consumers can use, in conjunction with other sources of information, to choose the right physician and protect themselves from dangerous providers.

Selecting a physician or physician network is a daunting task for consumers in today's managed care environment. The provision of health care has never been more market-driven. Consumers have never had to make as many decisions about all aspects of their health care. Concern about medical errors has never been greater. Choosing a provider is made even more difficult because most consumers must make this decision with very little information about a provider's competency. Hospitals and insurers have relied on the Data Bank to make important decisions about physicians for a decade, so why shouldn't consumers? For example, hospitals are required by federal law to query the Data Bank when making credentialing decisions about physicians.

Americans can find a great deal of comparative information on the Internet about cars, appliances and many other products and services. If they are willing to surf through a lot of "facts" that are of questionable validity, they can learn much about various diseases and treatments. In most cases, however, they can't learn much about their health care providers without a great deal of difficulty. Contrast this to the eroding medical and financial privacy that many consumers are experiencing. Barbara Walters, a New Jersey woman who successfully sued a New York physician for misdiagnosing breast cancer, told the *New York Daily News*, "I bet somebody could run me through a computer and find out whether I paid my bills, but we can't find out about doctors who have screwed up people's lives."⁴

The recent report regarding medical errors by the Institute on Medicine (IOM) demonstrates that far too many Americans face the serious possibility of an injury, or even death, due to medical mistakes in the hospital.⁵ Using the IOM's *low* estimate of 44,000 deaths per year, medical errors are the eighth leading cause of death in this country, ahead of breast cancer and AIDS. The IOM's *high* range estimate of 98,000 deaths a year would make medical errors the fifth leading cause of death, more than all accidental deaths. Not all medical errors are directly attributable to physician negligence, but the IOM report clearly demonstrates the need to take many steps to reduce medical errors, including providing consumers with more information about physicians' education, training and practice experience.

Some have suggested that consumers can't understand the limitations of the information available in the National Practitioner Data Bank, particularly regarding medical malpractice payments. They contend that consumers will not be able to put the information in perspective, ignoring the fact that H.R. 5122 requires that consumers be presented with fair and clear "contextual" information about malpractice payments. These opponents of H.R. 5122 are concerned that consumers will "misuse" the information and jump to inaccurate and unfair conclusions about providers, for instance, who have not committed malpractice but have settled a claim just to avoid an expensive court battle.

² Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about good, services, health, and personal finance; and to initiate and cooperate with individual and group efforts to maintain and enhance the quality of life for consumers. Consumers Union's income is solely derived from the sale of Consumer Reports, its other publications and from non-commercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports with approximately 4.5 million paid circulation, regularly, carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

³ The Center for Medical Consumers is a nonprofit healthcare consumer advocacy organization located in New York City. The Center receives no commercial support.

⁴ March 5, 2000, pg. 3.

⁵ *To Err is Human, Building a Safer Health System*, Institute of Medicine, National Academy of Sciences; November, 1999.

Fairness to providers is very important, but sadly, we in the consumer community have repeatedly heard this rather patronizing line of thought before. I will charitably call it the “ignorant consumer” argument. I first heard it in New York in 1986 regarding a proposal, later enacted into law, to provide maternity patients with data about the frequency that certain procedures, such as caesarian sections, were performed at hospitals. I heard it again a few years later when New York became one of the first states in the country to provide risk-adjusted cardiac surgery data on a hospital-by-hospital basis, and then later, when the state decided to expand this disclosure to many different surgical procedures. The sky didn’t fall in New York. Consumers and other purchasers did not misuse the information. They are better informed and better able to make purchasing or provider decisions and the laws are generally perceived to have been successful.

Nor will the sky fall with this legislation. Most people are perfectly capable of understanding the limitations of information that is provided to them. Consumers make similar distinctions every day regarding their healthcare choices. Moreover, the question of how consumers will use or misuse this information is no longer an academic one. We have real experience with what happens when this information is provided to the public in Massachusetts and in a growing number of other states. I urge this committee set aside the rhetoric on this question and look at the facts. As you have heard in prior testimony, representatives of the Massachusetts medical board report that none of the fears that were initially expressed about the misuse of this information have been realized. Moreover, the Massachusetts’ physician’s profiles are wildly popular with consumers.

Consumer access to the Data Bank is not a *substitute* for effective oversight and discipline of health care physicians at the state level, it is a *supplement* to these efforts. Empowering consumers with physician-specific information, combined with effective oversight by the states, will help reduce the number of incompetent providers, decrease medical errors and improve the quality of care. It is important, however, not to overlook the fact that most states have not enacted “physician profile” legislation. Moreover, of the states that do provide easily accessible physician-specific information, the type of information that is offered varies. In a transient age of “cybermedicine” and “telemedicine,” where physicians and treatments frequently cross state borders, it is important that consumers have access to “baseline” information about physicians, which states can then supplement if they wish.

The States Experience with Disclosure of Physician-Specific Data

A number of states have begun to provide comprehensive, user-friendly profiles of physicians, including California, Connecticut, Florida, Idaho, Massachusetts, New York, Oregon, Virginia, Texas, and Washington. Obviously, these profiles vary from state to state, but they often include the following information about physicians licensed in that state: education and training; specialty; board certification; malpractice settlements and/or judgments; criminal convictions, licensure revocation and state medical board and hospital disciplinary actions.

The Commonwealth of Massachusetts was the first state to create a physician profile system. Their program has become a model for other states and for this legislation. The program, which is accessible through a toll-free number and on the Internet, is widely used. Since the program began in November of 1996, consumers have requested nearly 4.9 million profiles.⁶

The Executive Director of the Massachusetts Board of Registration in Medicine, which administers the profile system, reports that many of the same concerns that are now being heard from the American Medical Association about opening up the National Practitioner Databank, were also expressed about physician profiles legislation in Massachusetts. None of these concerns have been realized. Moreover, the Massachusetts Medical Society, which publishes of the New England Journal of Medicine, actively supported the creation of physician profiles.⁷

In Massachusetts, physicians with reported medical malpractice payments have not been targeted with frivolous litigation. In fact, the rate of malpractice payments

⁶Written testimony of Nancy Achin Sullivan, Executive Director, Board of Registration in Medicine, Commonwealth of Massachusetts, House Commerce Subcommittee on Oversight and Investigations, March 1, 2000.

⁷“This is a victory for all patients in the state of Massachusetts. We filed this bill eighteen months ago because we are committed to meeting the needs of our patients... We see this bill as a ‘win-win’ situation for patients and physicians.” Massachusetts Medical Society News Release, August 1, 1996.

has actually declined twice as much as the national average since the profiles were initiated.⁸

There has been not been a “chilling effect” on required peer reporting, in order to avoid listing physicians in the profiles. On the other hand, the public has been able to understand and use the information, particularly regarding malpractice payments. The inclusion of “contextual” information about malpractice payments was key to this understanding. Moreover, consumers have insisted that malpractice information be included in the profiles. Otherwise, they do not find the profiles credible.⁹

H.R. 5122

H.R. 5122 is a strong piece of legislation precisely because it is modeled after the successful Massachusetts experience. It requires that the information available in the National Practitioner Data Bank be made available via the Internet to the public. This would include: malpractice settlement and jury awards; criminal convictions, if collected by state medical boards or reported by physicians; hospital and state medical board disciplinary decisions and physician “exclusions” by the Medicare or Medicaid program.

Regarding the disclosure of malpractice data, consumers would receive virtually the same “contextual” information as that provided in Massachusetts, as well as the amount of the payment and whether that amount is average, below average or above average for the medical specialty and the state. They would be informed that malpractice settlements (as opposed to jury decisions) are not necessarily a reflection of poor quality of care or an admission of guilt and that payment histories tend to vary by specialty and by state. This later disclosure is designed to insure that the malpractice histories of physicians who practice in “high-risk” specialties (such as neurology) or who live more litigious states are not unfairly compared to physicians in dissimilar circumstances.

In fact, the drafters of this legislation have bent over backwards to insure that consumers will understand the limitations of the information. The bill mandates a total of nine different “disclaimers” or pieces of contextual information about the data that consumers will see.

The malpractice information will be especially important in helping consumers avoid the very small number of “bad apple” physicians who have paid far more malpractice payments than average, but who have been allowed to continue practicing. One study of data in the National Practitioner Data Bank by consumer organizations found that only five percent of New York physicians had paid more than one medical malpractice claim over the past nine years.¹⁰ On the other hand, when the *New York Daily News* did a long series of investigative pieces on medical malpractice this year, they found that the “top” eight physicians in New York listed in the Data Bank had been required to make a total of 92 medical malpractice payments.

Our organizations recommend expanding the database in three specific ways, in order to make it more useful to the American public:Q02

- Collect information regarding nurse practitioners and physician assistants, who, in managed care settings, often deliver care to patients. At a minimum, the bill should specify who is covered under the definition of a physician.
- Require health care institutions other than just hospitals, such as ambulatory surgery centers and neighborhood health centers, to query the Data Bank when admitting a physician. This is especially important at a time when more surgeries procedures are being performed in such outpatient settings.
- Provide consumers or an individual who is acting on their behalf to submit a statement regarding malpractice settlements and decisions to which they were a party, as physicians would be allowed to do.

I will note for the record that the scope, depth and use of the National Practitioner Data Bank is imperfect. A number of important questions have been raised by Chairman Bliley and other members in hearings, including:

⁸Written testimony of Nancy Achin Sullivan, Executive Director, Board of Registration in Medicine, Commonwealth of Massachusetts, House Commerce Subcommittee on Oversight and Investigations, March 1, 2000.

⁹“... the one very consistent finding with every consumer focus group was that the exclusion of the [malpractice] information invalidated the entire process for the consumer. That they felt very strongly information needed to be there in order to have a sense that the product was truthful and full.” Oral testimony of Nancy Achin Sullivan, Executive Director, Board of Registration in Medicine, Commonwealth of Massachusetts, House Commerce Subcommittee on Oversight and Investigations, March 1, 2000.

¹⁰New York Public Interest Research Group, June 14, 2000.

- Why are hospitals apparently underreporting disciplinary actions against physicians? Sixty-six percent of all hospitals have never reported a disciplinary action.
- Are some physicians using the “corporate shield” to avoid being listed in the database, by convincing insurance entities or medical institutions to be cited as the defendant in a malpractice claim?
- Is data is transmitted to the Data Bank on a timely basis?

These are all legitimate questions. We urge the Committee to look into how to improve the Data Bank. However, as of now, the National Practitioner Data Bank provides the best available nationally accessible database with physician-specific information. Hospitals and insurers throughout the country rely on it. It can and should be improved, but this should not be used as an excuse to delay access to consumers. In fact, given the kind of attention that the public, businesses, and other health care professionals would pay to the Data Bank if this bill were enacted, it is much more likely that the Data Bank will be improved as an “open” database rather than a “closed” one.

Thank you very much for the opportunity to offer a consumer perspective on this issue. I look forward to working with Chairman Bliley, Mr. Dingell and the members of this committee to make this proposal a reality for American consumers.

Chairman BLILEY. Thank you.

Now we will now hear from Dr. Richard Corlin, President Elect, American Medical Association. Dr. Corlin.

STATEMENT OF RICHARD F. CORLIN

Mr. CORLIN. Thank you, Mr. Bliley. Good afternoon, sir.

My name is Richard Corlin. I am a gastroenterologist in private practice in Santa Monica, California; and I am President Elect of the American Medical Association. On behalf of our 300,000 physician and medical student members, I appreciate the opportunity to testify today before you.

Safeguarding the millions of patients in our health care system is one of the AMA’s highest priorities. We need to ensure patients have access to accurate and relevant information to help them choose among health insurance plans, physicians and other health care providers. We believe that the best approach to meet patients needs is to enhance the State-based systems already in place.

States license and regulate physicians, not the Federal Government, and have the authority and responsibility to discipline doctors and other health care professionals and provide pertinent information to the public. State agencies, along with the Federation of State Medical Boards, or FSMB, are at the forefront of providing consumers with relevant information on health care providers and are taking appropriate steps to rid the health care system of incompetent providers.

States and the FSMB, which operates a central repository for formal actions taken against physicians by State licensing boards, have made tremendous advances in the last few years in developing physician profiling systems. For example, the FSMB has nearly completed its All Licensed Physicians Project, or ALPP, which will be a publicly accessible, Internet-based system that will collect all actions by State medical boards and compile them in the FSMB’s Board Action Data Bank. Upon completion, the ALPP will be the most comprehensive compilation of information on licensed physicians that is available anywhere.

In all 50 States and the District of Columbia, information is now available to the public through their medical licensing boards. The FSMB web site includes a directory of every State medical board,

with a direct Internet link to most of these boards, and that number is increasing. Also, 29 States have initiated their own Internet-based physician profiling system, including the State of Arizona.

In addition to the systems already in place in these States, the FSMB has developed a model profiling system that includes the most comprehensive and up-to-date information available on physician profiling. This model will assist States as they consider legislation on this subject in their upcoming legislative sessions starting after the first of the year.

The well-balanced and complete information that States and the FSMB are working on to give patients stands in stark contrast to the National Practitioner Data Bank, which is not a taxpayer-supported institution but is a user-fee-supported institution. The NPDB was designed for a specific and limited purpose, to be used as a flagging mechanism for State medical boards and hospitals to access. It does not contain information about overall qualification of physicians and other health care providers and was never intended to.

On March 16, the Division of Quality Assurance stated in testimony before the Subcommittee on Oversight and Investigations that nothing in the Data Bank's information is intended to produce an independent determination about the competency of an individual physician. It rather is intended to supplement a comprehensive and careful professional peer review. Three-quarters of the reports in the NPDB pertain to medical malpractice payments. Malpractice payments seldom correlate with findings of negligent care. A New England Journal of Medicine study indicates that only one in five of indemnity payments for malpractice filings that were brought are related to negligent medical care. Some of our Nation's best physicians are involved in settlements, yet the NPDB data does not reflect their high level of competence.

As an aside I might say, if anyone in this room were unfortunate to require the urgent services of a neurosurgeon and we were referred to a neurosurgery group that had had six malpractice cases filed against them in the past year, and that is data that is available by the State medical board in that State, we would be concerned about the competency of that group until we realized that they are the full-time faculty of neurosurgery of Harvard University. We need to put this data into some real context.

Also, in many cases——

Mr. BILIRAKIS [presiding]. Please summarize, Doctor.

Mr. CORLIN. Yes, sir.

In many cases, insurance companies settle malpractice cases purely for economic reasons, of it being cheaper to settle the claim than to fight the claim. We think that Congress should support the efforts already under way in the States and by the FSMB to provide the most relevant information to patients and to ask for reporting as to where those system developments stand and not to take action that would potentially undermine these efforts.

Thank you.

[The prepared statement of Richard F Corlin follows:]

PREPARED STATEMENT OF RICHARD F. CORLIN, PRESIDENT-ELECT, AMERICAN
MEDICAL ASSOCIATION

Good morning, Mr. Chairman and members of the Committee, my name is Richard F. Corlin, MD. I am a gastroenterologist in private practice in Santa Monica, California, and currently serve as President-Elect of the American Medical Association (AMA). On behalf of our 300,000 physician and medical student members, I appreciate having the opportunity to testify on the National Practitioner Data Bank (NPDB).

The AMA commends the Committee for addressing issues surrounding the safeguarding of the millions of patients in our expansive American healthcare system. As you know, this system continues to undergo dramatic change, and with this change there is a pressing need to ensure that patients have the best information available to help them choose among the many competing physicians and other health care professionals seeking the privilege to treat.

The AMA is strongly committed to the objective of improving patient safety and protecting patients from preventable harm caused by incompetent or unethical practitioners. In fact, beyond the initiatives that we outlined for this committee in our February 9, 2000, statement for the Record on the 1999 Institute of Medicine (IOM) Report on health care errors, the AMA regularly reviews its membership master file and reports to the NPDB those physicians we expel for reasons relating to peer reviewed breaches of quality of care and patient safety.

As we search together for ways to best safeguard patients, we must continue to question whether disseminating to the public raw, unsynthesized data from existing federal repositories would improve the quality of health care for patients. Or, instead, do we need to advocate for other private sector or state-based mechanisms that would provide the public with relevant, reliable, verified, accurate, and contextual information? In our opinion, perfecting mechanisms already in place hold the best chance of meeting patients needs. This is the view of opinion leaders in health care and finds its firm basis in the Congressional intent and history surrounding the NPDB.

On February 9, 2000, the House Commerce Subcommittee on Health and Environment, the Subcommittee on Oversight & Investigations, and the Committee on Veterans' Affairs Subcommittee on Health held a joint hearing on the IOM Report on health care errors. During this hearing a Majority member of the Subcommittee on Oversight and Investigations posed the question to the entire third panel of witnesses of whether the NPDB should be expanded beyond its intended purpose. The entire panel responded in the negative. The panel was comprised of such health care experts as Dennis O'Leary, MD, Joint Commission on Accreditation of Healthcare Organizations; William Golden, MD, American Health Quality Association; Michael Langberg, MD, Cedars-Sinai Health System; Daniel Perry, Alliance for Aging Research; and Mary Foley, RN, American Nurses Association.

These views echo what Congress intended when it designed the NPDB. Congress did not design the NPDB to disseminate information at large. In fact, the House Committee on Energy and Commerce (now the Commerce Committee) emphasized this view in its Committee Report on the Health Care Quality Improvement Act of 1986 (HCQIA) (Rept. 99-903), which created the NPDB. For example, in discussing malpractice settlement data the Committee Report stated that the Committee was "confident that those authorized under the bill to gain access to this information will have the awareness and sensitivity to use it responsibly" (p.14). Further, the Committee stated that "it is essential to collect and disseminate these data to those in the health care community who make judgments about the competence and professional conduct of health care practitioners" (p. 13).

These statements are as true today as they were then. In fact, in a February 24, 2000, letter to the Chairman of this Committee, the Department of Health and Human Services (HHS) stated that "...serious privacy concerns are raised by the specter of public disclosure of NPDB information. The information collected in the data bank was never intended to serve as a complete history but rather as an important supplement to comprehensive and careful professional peer review of a practitioner's credentials. As a result, the statute puts in place confidentiality protections that create a strong expectation of privacy among the hundreds of hospital entities and insurance companies required to make regular and detailed submissions to the data bank. The principle of confidentiality has governed the operation of the NPDB since its inception, and is an integral part of its operations and procedures." HHS also emphasized in the letter that "Congress's express intent that such information be kept confidential is clearly specified in the statute..."

The NPDB was established as a flagging mechanism to improve the quality of health care by encouraging state licensing boards, hospitals, and professional soci-

eties to identify and discipline physicians who lacked the requisite competency and high ethical standards required for patient care. At the time there was concern that states did not have the resources to advance quality of care initiatives. The NPDB was also intended to prevent physicians who lost their license in one state from moving to another state without disclosing disciplinary actions taken against them.

The AMA supports the goal of preventing physicians from moving state to state or hospital to hospital without disclosure of adverse peer reviewed actions taken against them. We respectfully disagree, however, that the NPDB is the appropriate mechanism by which information on physicians and other health care providers should be disseminated beyond its intended purpose. Opening the NPDB would not solve the problem of weeding out bad physicians and other health care providers from the health care system.

Since the establishment of the NPDB, Congress has consistently recognized that only medical credentialing and licensing entities have the resources and expertise needed to evaluate NPDB reports and analyze how the reports reflect the competency of health care professionals. In addition, public disclosure of the NPDB data was discussed at length in the 1986 and subsequent debates on the NPDB, including the 1995 debate during the Senate Labor & Human Resources Committee's mark-up of the Health Care Liability Reform and Quality Assurance Act of 1995 (S. 454). After extensive deliberation in each debate, greater dissemination of the NPDB's data was rejected.

There are other influential commissions and institutes that have studied ways to improve the quality and safety of health care and have come to the same conclusion. In 1998, the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry considered, then rejected a recommendation to open the NPDB. This matter was thoroughly discussed by the Commission, with the Commission's 1998 report stating that the "current systems to reduce or prevent errors in the provision of health care services tend to focus too much on individual practitioners and not enough on system problems" (p. 155). Additionally, the Commission recommended that steps be taken to improve error reporting and focus on determining the causes of error. Similarly, the 1999 IOM Report on health care errors discussed but did not recommend opening the NPDB.

The AMA agrees with the above cited opinion leaders, Congressional drafters of the NPDB legislation, HHS, the President's Quality Commission, and the IOM Report that the NPDB was designed for a limited purpose and is not the mechanism upon which to provide patients with the information about the overall qualifications of physicians. The licensing of physicians and other health care providers has always been within the purview of the states, and the AMA strongly agrees that this should remain the case. We see no value in expanding programs that would infringe on the purview of state-based licensing and state medical boards.

Historically, states tracked physician information related to education, training, licensure status, disciplinary actions by state medical boards and hospitals, and criminal offenses. Recently, state physician profile programs have begun expanding to include no-contest pleas, pending complaints, medical malpractice data, malpractice comparison, instances of "derogatory information," and "findings of unprofessional conduct."

In fact, a federal government response is not necessary because the states and the Federation of State Medical Boards (FSMB) are far ahead of Washington in addressing these concerns and have made tremendous advances in the last few years in developing profiling systems. Also, most state medical licensing boards have recognized profiles as a significant resource for consumers and have elected to address the profiling issue voluntarily. To date, more than half of state licensing boards have initiated physician profiling systems whereby information on physician licensure, medical education and training, specialty board certifications, disciplinary actions, criminal convictions, and liability settlements may be accessed by the public through the Internet.

State medical boards are an important gateway to this provider profiling information. At the state level, medical boards are able to access accurate data and can take affirmative action through the control of medical licenses and have authority to enforce disciplinary actions on medical practitioners. They are uniquely positioned—both historically and practically—as the primary source of information about the physicians they regulate.

The FSMB is already working hard to help states develop profiling systems. Earlier this year the FSMB released a report on the findings and recommendations of its Special Committee on Physician Profiling. This Committee was established in April 1999 to review the current physician profiling information available to the public and determine what information is most helpful. The Special Committee's report includes the most comprehensive and up-to-date information on physician

profiling available. The FSMB anticipates this report will be used as a catalyst for legislation at the start of the state legislative session. We strongly recommend that Congress consult with the FSMB on their findings and recommendations and fully consider its activity prior to acting on any legislation that may thwart FSMB's or any state's effort to further develop a physician profiling system.

The FSMB is near completion of its All Licensed Physician's Project (ALPP), which will be a publicly accessible, Internet-based system that will collect all actions by state medical boards and compile them in the FSMB's Board Action Data Bank. The ALPP also includes a concerted effort to obtain biological, educational, and licensure information on every physician licensed to practice medicine. The ALPP will be the most comprehensive compilation of information on licensed physicians available. FSMB expects to have this service available early next year. Further, the FSMB's Web site ([Http://www.fsmb.org](http://www.fsmb.org)) currently includes a directory of every state medical board, and a direct Web link to most of these boards.

The well balanced and complete information that states and the FSMB are working to give to patients stands in stark contrast to the NPDB, which is administered by the Health Resources and Services Administration. According to the 1999 NPDB Annual Report, cumulative data show that at the end of 1999, 75.8 % of all NPDB reports pertain to so-called "Medical Malpractice" payments.

Malpractice claims seldom correlate with findings of negligent care in the medical record. Thus, reports made to the NPDB on paid malpractice claims provide, at best, an incomplete and haphazard indicator of a practitioner's competence or quality. The HCQIA acknowledges that malpractice payments do not indicate that malpractice has occurred. Section 427(d) states:

Interpretation of Information.—In interpreting information reported under this part, a payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred.

The Department of Defense and the Department of Veterans Affairs recognize the serious problems with correlating lawsuits with physicians' competence or negligence. Under the DOD and VA health systems, physicians are not reported to the NPDB when a claim is settled on their behalf unless a panel of peers found negligence or incompetence. Representatives of the DOD and VA told the AMA that the correlation of settled claims and actual negligence is about 30%. Also, a study published in the *New England Journal of Medicine* indicated that only 23.8% of claims closed with an indemnity payment resulted from negligent medical care. (see, 335 *New Eng. J. Med.* 1963 (1996)).

The NPDB system for collecting medical liability settlements and verdicts is fatally flawed and an exceedingly inaccurate measure of the competence of a physician. Even some of our nation's finest physicians who specialize in high-risk cases or state-of-the-art procedures are involved in settlements.

In addition, the NPDB makes no adjustment for high-risk patients or state-of-the-art medical procedures. Each day many people would die or become severely incapacitated if it were not for the high-risk medical procedures by dedicated and very capable physicians. High-risk obstetrics, open-heart surgery, and neurological surgery to relieve the effects of Parkinson's Disease are just a few examples of commonly used high-risk procedures. Only the most highly qualified and competent physicians are willing to perform such high-risk procedures that offer the only hope for relief of debilitating symptoms or life-threatening conditions. The NPDB information is flawed and misleading because it does not adjust for the risks involved in these procedures. Unrestricted public access could lead patients away from utilizing some of our nation's most talented physicians.

Also, advances in medicine are made only by utilizing new procedures and drugs. Someday these state-of-the-art procedures will be as common as yesterday's new innovations. But, for the same reasons as above, these pioneering physicians could be unfairly evaluated by a systematic release of gross settlement results.

Further obscuring the relevance of malpractice claims data in the NPDB is the fact that many cases are settled without the consent of the physician. Many insurers disallow "consent to settle" clauses in their contracts with physicians. Also, under some state laws "consent to settle" clauses are prohibited. Without this clause, the insurer can disregard the physician's right to defend himself or herself on the merits. Such decisions are purely economic and do not take into consideration the quality of medical care. Nevertheless, the settlement and physician are reported to the NPDB.

The AMA believes that the provisions in H.R. 5122 (introduced by Chairman Bliley on September 7, 2000) would not resolve the systemic problems with the NPDB as outlined above. The bill's attempt to convert the NPDB from a flagging system for state licensing boards and hospitals into a consumer information tool falls substantially short of the profiling systems developed (or being developed) by states and

the FSMB. The NPDB data was never intended to provide a complete history of a physician, but rather be a supplement to a professional peer review of a physician's credentials.

In addition, unlike the time before the NPDB was created, states are now allocating substantial financial resources to the development and maintenance of their physician profiling programs. Just as many of these programs are getting under way, we believe that tampering with the NPDB would significantly undermine these efforts by the states. States license and regulate physicians and are in a better position to discipline doctors and provide pertinent information to the public. Also, we believe that the FSMB's new ALPP will surpass the NPDB regarding disciplinary information on physicians who move from one state to another.

Conclusion

Improving patient safety and protecting patients from preventable harm caused by incompetent or unethical health care practitioners are issues strongly supported by the AMA. We are encouraged that many states and the FSMB are developing systems to provide relevant information on their licensed health care providers. We respectfully disagree, however, that the NPDB is a mechanism by which information on physicians and other health care providers should be disseminated beyond its intended purpose. Other state-based systems are currently being developed and deserve deferential consideration. Congress should fully consult with the FSMB regarding its report on state-based profiling systems. Finally, this committee should not move forward on H.R. 5122 or any other legislation that would substantially undermine the efforts at the state level and by the FSMB to develop physician profiling systems that provide accurate and relevant information to patients.

We appreciate the opportunity to discuss this matter before the committee and would be pleased to answer any questions.

Mr. BILIRAKIS. Thank you very much, Doctor.

Dr. Hochman, on behalf of the American Hospital Association. Please proceed, sir.

STATEMENT OF RODNEY F. HOCHMAN

Mr. HOCHMAN. Mr. Chairman, I am Dr. Rodney Hochman, Chief Medical Officer and Senior Vice President of Sentara Healthcare in Norfolk, Virginia, and a board-certified internist and rheumatologist. I am here today on behalf of the American Hospital Association's nearly 5,000 hospital, health system, network and other health care provider members. We are pleased to have the opportunity to testify on H.R. 5122, the Patient Protection Act of 2000, and the issue of public access to the National Practitioner Data Bank.

Sentara Healthcare is a not-for-profit system which serves more than 2 million residents in southeastern Virginia and northeastern North Carolina. We operate 70 care-giving sites, including six hospitals with a total of 1,800 beds. More than 2000 physicians are members of our hospitals and medical staffs. As Sentara's Chief Medical Officer, one of my role is to ensure our staff provides high-quality services and that our credentialing and peer review processes are effective. Nothing is more important than the safety of our patients.

At Sentara, like most hospitals and health systems across the United States, we conduct an exhaustive background check on our medical staff before a physician is allowed to treat one patient in our facilities. This is done by a 40-member team which includes physicians, nonphysicians and community representatives. We inquire about a physician's educational, personal and professional background, malpractice history and any career gaps. We go directly to the medical school, the State licensing boards and other

hospitals where the physician has practiced to verify his or her background.

We also query the National Practitioner Data Bank, an essential step in our process. At Sentara, we use the information to supplement our other credentialing activities and as a possible indication whether there is a problem.

Opening up the Data Bank to the general public, however, would breach the promise of confidentiality under which it was established, undermine the peer review process and impede the goal of promoting quality care. The confidentiality of the peer review process allows practitioners to candidly discuss the qualifications of their peers. Hospitals depend on the peer review process to ensure that their practitioners are capable. We must not do anything that would be detrimental to this essential and confidential process, which is an important tool for the assurance of quality care.

Congress created the Data Bank as a resource for health care professionals. Its primary purpose is to alert health care facilities, licensing boards and professional societies to the possibility of incompetent or dangerous performance by a health care practitioner. The enacting statute in fact argues against allowing consumers access to the Data Bank.

Consumers do have a legitimate interest in knowing that the people providing health care are competent. In fact, the AHA agrees that some information would be helpful to consumers, for example, public disclosure regarding licensure actions and criminal convictions.

At the same time, malpractice information must be put in the proper context before it is released to the public. H.R. 5122 does attempt to place malpractice reports in some context, but its current design does not differentiate between payments made and situations involving substandard care and payments made for a variety of other reasons such as to eliminate the defense of a frivolous or nonmeritorious claim or to minimize the cost of litigation.

There may be numerous reasons for settling the dispute, not one of which is related to the quality of care. It would not enable a consumer to make the fundamental decision to determine if a practitioner is not competent to provide needed care.

Mr. Chairman, the AHA and its members take seriously our legal reporting obligations to the Data Bank. Restriction and loss of privileges are serious actions, but these are meted out only as a last resource, only after alternative intervention attempts have failed.

Questions have been raised about the rate of reporting by hospitals. These questions are based largely on a comparison of projections made when the Data Bank was created and actual reporting since its inception. The absence of a report does not reflect the absence of effective oversight of health care practitioners. Hospitals are accountable for care within their facility and bear legal responsibility.

We are committed to delivering high-quality care to the communities we serve, the communities in which we live. We are committed to working with Congress to ensure that consumers can obtain the right type of health care information placed in the appro-

priate context so we may achieve our ultimate goal, providing quality health care to our communities.

Thank you.

[The prepared statement of Rodney F. Hochman follows:]

PREPARED STATEMENT OF RODNEY HOCHMAN, CHIEF MEDICAL OFFICER AND SENIOR VICE PRESIDENT, SENTARA HEALTHCARE ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman, I am Rodney Hochman, MD, chief medical officer and senior vice president of Sentara Healthcare in Norfolk, Virginia. I am here today on behalf of the American Hospital Association's (AHA) nearly 5,000 hospital, health system, network and other health care provider members. We are pleased to have the opportunity to testify on H.R. 5122, the Patient Protection Act of 2000 and the issue of public access to the National Practitioner Data Bank (NPDB).

Sentara Healthcare is a not-for-profit health system, which serves more than 2 million residents in southeastern Virginia and northeastern North Carolina. We operate more than 70 caregiving sites, including six hospitals with a total of more than 1,800 beds. Sentara Healthcare employs more than 180 physicians representing 20 medical specialties and subspecialties. Our hospitals provided care for more than 250,000 outpatient and emergency department visits and close to 65,000 hospital admissions in 1999. More than 2,000 physicians are members of our hospitals' medical staffs.

I am a board-certified internist and rheumatologist. As Sentara's chief medical officer, I am responsible for the clinical effectiveness programs, physician integration efforts, and medical management issues for its six-hospital system and 300,000 member HMO. One of my roles is to work with our hospitals' medical staffs to ensure their credentialing and peer review processes are effective. Twelve employed physicians, functioning as medical directors under my direction, facilitate and monitor these processes across Sentara. I also participate as an ex-officio member of our board's Medical Affairs Committee, which is responsible for the quality of care provided in our hospitals.

The AHA supports the goals of the Health Care Quality Improvement Act (HQIA), under which the National Practitioner Data Bank was created. The act recognizes the importance of encouraging and supporting effective professional peer review to help protect consumers from incompetent or dangerous performance by practitioners. The AHA and its members engage in a range of activities that help hospitals and health systems deliver the highest quality care. One of the most important of these is the peer review and quality assurance activities that occur every day in hospitals across the country.

We appreciate and understand efforts to provide consumers with information to make informed health care decisions. We are concerned, however, that current proposals would have a chilling effect on the peer review and quality improvement (QI) processes that are essential to providing the quality care consumers deserve and expect.

CREDENTIALING AND PEER REVIEW ACTIVITIES

At Sentara, like most hospitals and health systems across the United States, we conduct exhaustive background checks on our medical staff before a physician is allowed to treat patients at our facilities.

Initially, physicians applying for hospital privileges are subject to an intense screening process. The credentialing application inquires about a physician's educational, personal and professional background, malpractice history and any career gaps. We then conduct primary source verification. For example, we verify with the physician's medical school that he did indeed graduate; we check with the Board of Medical Specialties that he is a board-certified physician, and we confirm with the state licensing board that he is in fact licensed by the state to practice medicine. We inquire about past performance on quality issues at each hospital at which the physician has had privileges, and we also query the National Practitioner Data Bank.

The National Practitioner Data Bank contains information on medical malpractice payments, adverse licensure actions, adverse actions taken by physician professional societies, and suspension of hospital privileges for more than 30 days. Hospitals by law are mandated to query the data bank. At Sentara, we use the information to supplement our other credentialing activities, and as a possible indication that there is a problem.

Sentara uses a three-tier screening process. First, our Credentialing Committee, which consists of 12 physicians from many different specialties, reviews a physician's complete credentialing application. Next, the Credentialing Committee's recommendation is forwarded to the Medical Executive Committee, which consists of 15 physicians including the officers of the medical staffs and the chiefs of each clinical department. Final approval or denial is made by our board's Medical Affairs Committee.

Physicians are subject to re-credentialing every two years. At that time, physicians formally attest to whether anything has changed since the initial credentialing process. The department's quality improvement chairman assesses this information along with the physician's quality assurance profile for the previous two years and makes a recommendation to the department chairman. We also query the National Practitioner Data Bank and state licensing board for reports of any adverse actions. The department chair makes a recommendation to the Credentials Committee. The Credentialing Committee reviews all information and makes a recommendation to the Medical Executive Committee, and the Medical Affairs Committee makes a final decision.

Besides this aspect of the formal peer review process, we have ongoing QI activities designed to flag possible quality of care problems. For example, at Sentara the following situations automatically initiate a QI review: a death; a return to the OR within 48 hours; a return to ICU; and re-admissions for certain diseases. In addition, patient complaints and incident reports, which can be initiated by any staff member, are reviewed. As part of the QI review process, a QI nurse investigates the incident/complaint and files a report with the department's QI Committee, and the physician has an opportunity to present his case. The department QI Committee reviews these cases and forwards appropriate ones to the hospital QI Committee. If the hospital QI Committee identifies a quality concern, the case is sent to the Medical Executive Committee for review and possible corrective action. Records for such cases are kept in the physician's QI file and reviewed at the time of re-credentialing.

Hospitals actively monitor the quality of patient care and services. Every health care organization must ensure that its workforce, including all clinical staff affiliated with the organization, is competent, adequately credentialed and trained. As you can see, querying the National Practitioner Data Bank is an essential step in the credentialing and QI process. However, it is only one part of the equation.

OPENING THE DATA BANK

Consumers have a legitimate interest in knowing that the people who provide their care are competent. But completely opening up the data bank to public scrutiny would do much more harm than good for two reasons. First, public disclosure of the data bank's contents would undermine the peer review process in hospitals across America—thus impeding the data bank's goal of promoting quality care. Congress recognized the importance of confidentiality and embraced it when creating the National Practitioner Data Bank.

Candor and confidentiality are essential for frank and open evaluations regarding a physician's competency. H.R. 5122 would make adverse credentialing decisions available to the public, thus significantly altering Congressional intent. The normal tensions created by peer review would be significantly heightened if this were done. Disclosure to the public could cause caregivers to be less forthcoming about their own mistakes and less likely to report errors made by their peers, when the effect would likely result in unfairly stigmatizing the individual and have an adverse effect on quality improvement activities.

The threat of public access to adverse credentialing decisions in the data bank may force mistakes underground, and hospitals and practitioners would lose the opportunity to analyze what went wrong and make the necessary changes to ensure that the mistakes do not happen again. Such a lack of review potentially jeopardizes the ability of caregivers to achieve the ultimate goal—providing high quality health care.

Second, the data bank was not designed to be a consumers' tool, but rather a resource for health care professionals. One fear is that consumers would misinterpret the malpractice settlement reports. In fact, in the statute that created the data bank, Congress specifically rejected making its reports public, and cautioned that a settlement does not necessarily indicate that malpractice occurred.

For a consumer trying to evaluate a potential caregiver, knowing that a settlement occurred, the level of the award, and its relation to other awards within the medical specialty field is misleading. The data bank does not differentiate between payments made in situations involving substandard care and payments made for

other reasons, such as eliminating defense of a frivolous or nonmeritorious claim, or to minimize the cost of litigation. There may be a whole host of reasons for settling the dispute, not one of which is related to quality of care. Such information made public could be misleading, cause serious consequences for a practitioner and unnecessarily undermine the public confidence in the physician and hospital.

While H.R. 5122 does attempt to place malpractice reports in some context, it would not enable a consumer to make the fundamental decision—to know if a practitioner is not competent to provide needed care.

REPORTING PHYSICIANS TO THE DATA BANK

The AHA and its members take seriously their legal reporting obligations to the NPDB. Restriction and loss of a physician's hospital privileges is a serious action. Hospitals usually suspend a doctor's clinical privileges only as a last resort, after they've tried alternative interventions, such as the use of supervision, requiring medical education, and short-term limitations on privileges.

Questions have been raised about the rate of reporting by hospitals. These are based largely on a comparison of estimates made when the data bank was created and actual reporting since its inception. The fact that a hospital has not reported a specific number of adverse credentialing action to the data bank based on estimates does not mean they are not effectively overseeing health care practitioners. QI programs like the one described at Sentara can help prevent a situation that would lead to a report to the data bank. The up-front credentialing by hospitals, as described at Sentara, also plays an important role in selecting competent practitioners. The potential consequences for hospitals that are involved in adverse actions are significant, including legal challenge by the affected physician. The sanction for failing to report is also significant and results in loss of immunity under HQIA.

CONCLUSION

Hospitals are accountable for the care within their facility and bear legal responsibility. We are committed to the delivery of high quality care to the communities we serve. Peer review is essential for the assurance of quality care, and confidentiality of peer review activities is essential for the success of the process.

The data bank's primary purpose is to serve as a "flagging" system for health care facilities, licensing boards, and professional societies. The purpose is to alert these agencies to the possibility of incompetent/dangerous performance by a health care practitioner. The data bank was not designed by Congress as a public tool.

Opening the National Practitioner Data Bank to the public would breach the promise of confidentiality under which the data bank was created and reports are submitted, and not achieve the goal of providing consumers with valid or practical information. The public deserves to have information that is meaningful and could help them make better decisions about their health care.

Improving and maintaining quality health care is better served by reforms that foster an environment promoting candor. Candor is absolutely critical if we are to be truly successful in identifying and learning what makes the health care system safer. We need to create a non-punitive culture that will encourage people to participate in peer review—the frontline protection for health care quality.

Mr. BILIRAKIS. Thank you very much, Doctor.

Dr. Loniewski. Am I close?

Dr. LONIEWSKI. Very close, very good.

STATEMENT OF EDWARD A. LONIEWSKI

Mr. LONIEWSKI. Mr. Bilirakis, members of the committee, my name is Edward A. Loniewski, DO. I am a retired certified orthopedic surgeon from Plymouth, Michigan, and past president of the American Osteopathic Association, the AOA. I am a member of the National Practitioner Data Bank Executive Committee.

On behalf of the 44,000 osteopathic physicians represented by the AOA nationwide I appreciate the opportunity to testify on the Patient Protection Act of 2000 and specifically the issue of public disclosure of information contained in the National Practitioner Data Bank, the NPDB.

A full discussion of the AOA's position is found in my prepared remarks. I will just highlight a few today.

The AOA opposes the NPDB and any attempt to make information in that Data Bank public in its current form, because that information regarding malpractice settlements and adverse actions can be misleading. Therefore, we must also oppose H.R. 5122, the Patient Protection Act of 2000. While your bill attempts to put medical malpractice information in context and provides disclaimer information, H.R. 5122 falls short of adequately and properly explaining such information.

Mr. Chairman, we share your desire to ensure that incompetent physicians, dentists and other health care providers are not allowed to continue harming patients. However, this legislation is not the appropriate means of doing so.

Although the AOA opposes the current NPDB, the Association supports a Federal Data Bank that is open to the public if and only if the information accurately reflects the negligence of the practitioner. Such information should be submitted by a State licensure board which has professionally conducted a peer review of the physician in question. Information provided by State licensure boards could then be made public and would affect the competency of the provider as evaluated by their peers.

While the AOA does not oppose a Federal Data Bank open to the public, H.R. 5122 does not provide contextual information that has undergone true peer review. Negligent practitioners can be identified when a professional organization, licensing board or true peer review organization comprised of physicians of same license and specialty rules that a practitioner has been negligent in his or her performance of patient care.

The public has a right to know, but I emphasize that before any information is made public it must pass the test of true peer review. Unfortunately, the Patient Protection Act of 2000 does not utilize the key element of physician evaluation, and therefore we feel that the information is not suitable for public interpretation of a physician's competency.

State medical and licensure boards need to do a much better job of sharing information between different States. This common sense and simple solution would go a long way toward weeding out truly negligent and incompetent physicians.

In closing, Americans have a right to the best medical care possible, and physicians have a right to be treated fairly when under review by the public, government agencies, review boards, hospitals and their peers.

Mr. Chairman, the public would be better served by more than just misleading physician malpractice information. For instance, information regarding a physician's education, training, insurance plan participation, hospital appointments and practicing privileges would be useful and appropriate for public access. The sole purpose of your legislation is clearly the public dissemination of medical malpractice information and seems suspiciously anti-physician rather than pro-patient.

I encourage you to reconsider carefully your position regarding this issue and re-examine the propriety, usefulness and accuracy of the NPDB information you seek to make available to the public.

Also, though, the AOA has serious concerns regarding both the timing of H.R. 5122 and the title of the bill. A heated debate has been stirring on Capitol Hill for the entire 106th Congress regarding the Patients' Bill of Rights, with numerous versions being called a, quote, Patient Protection Act. The two issues should not be confused nor should the Patients' Bill of Rights be forgotten or lost in the shuffle of a last-minute legislative free-for-all in the waning days of the 106th Congress.

The protections encompassed in the House-passed, bipartisan consensus, Managed Care Improvement Act of 1999, H.R. 2723, are the real protections our patients need and deserve.

Thank you for the opportunity to testify today. The AOA stands ready to participate in a bipartisan effort to develop a public Data Bank that will truly provide consumer protection. Thank you, Mr. Chairman.

[The prepared statement of Edward A. Loniewski follows:]

PREPARED STATEMENT OF EDWARD A. LONIEWSKI ON BEHALF OF THE AMERICAN
OSTEOPATHIC ASSOCIATION

INTRODUCTION

Chairman Bliley, Congressman Dingell, and Members of the Committee, my name is Edward A. Loniewski, D.O. I am a retired orthopedic surgeon from Michigan and past president of the American Osteopathic Association (AOA). I am a member of the National Practitioner Data Bank Executive Committee. On behalf of the 44,000 osteopathic physicians represented by the AOA nationwide, I appreciate the opportunity to testify on the "Patient Protection Act of 2000" and specifically, the issue of public disclosure of information contained in the National Practitioner Data Bank (NPDB).

The AOA is the national professional organization for osteopathic physicians in the United States. In addition, the AOA is the recognized accrediting authority for colleges of osteopathic medicine, osteopathic postdoctoral training programs and osteopathic continuing medical education.

Osteopathic medicine is one of two distinct branches of medical practice in the United States. While allopathic physicians (M.D.) comprise the majority of the nation's physician workforce, osteopathic physicians (D.O.) comprise more than five percent of the physicians practicing in the United States. Significantly, D.O.s represent more than 15 percent of the physicians practicing in communities of less than 10,000 and 18 percent of physicians serving communities of 2,500 or less.

AOA'S POSITION

The AOA opposes the NPDB and any attempt to make information in that data bank public in its current form. We take this position because the information regarding malpractice settlements and adverse actions contained in the Data Bank can be misleading. Therefore, we must also oppose the Chairman's H.R. 5122, the "Patient Protection Act of 2000." While the bill attempts to put medical malpractice information in context and provides disclaimer information, H.R. 5122 falls short of adequately and properly explaining such information.

Although the AOA opposes the current NPDB, the Association does support a federal data bank that is open to the public if the information accurately reflects the negligence of the practitioner. Such information should be submitted by state licensure boards which have professionally conducted a peer review of the physician in question. Information provided by state licensure boards could then be made public and would reflect the competency of a provider as evaluated by their peers. As I will emphasize later in my testimony, these practitioners can be best identified through true peer review. Mr. Chairman, we share your desire to ensure that incompetent physicians, dentists and other health care providers are not allowed to continue harming patients, however this legislation is not the appropriate means of doing so. I highlight the following reasons for not making public the information held in the NPDB.

1. THE NPDB WAS NOT DESIGNED FOR PUBLIC CONSUMPTION. THE INFORMATION IN THE NPDB SHOULD NOT BE USED BY THE PUBLIC TO DETERMINE THE COMPETENCY OF THEIR PHYSICIAN, DENTIST OR HEALTH CARE PROVIDER.

The NPDB was established through Title IV of the Health Care Quality Improvement Act of 1986, as amended. The intent of the law was to improve the quality of health care. Hospitals, state licensing boards and other health care entities including professional societies were encouraged to identify and discipline those who engage in unprofessional behavior. Such groups would then restrict the ability of incompetent physicians, dentists and other health care practitioners to move from state to state without disclosure or discovery of previous damaging or incompetent performance.

The NPDB is designed to act as a clearinghouse of information. Its records include data relating to medical malpractice settlements and judgements as well as adverse actions taken against the licenses, clinical privileges and professional society memberships of physicians, dentists, and other licensed practitioners. The Data Bank also contains information regarding practitioners who have been declared ineligible to participate in Medicare and/or certain other state health care plans under the Social Security Act.

2. MALPRACTICE PAYMENT INFORMATION IS NOT PROVIDED IN THE PROPER CONTEXT TO EVALUATE THE SKILLS OF A PHYSICIAN.

The NPDB places much emphasis on medical malpractice. When a medical malpractice payment is made on behalf of a practitioner, payment information must be reported to the Data Bank. However, settlement of a medical malpractice claim may occur for a variety of reasons that do not reflect negatively on the competence or conduct of the practitioner. In many cases, a physician's malpractice insurer will settle the case—not because the practitioner is guilty of malpractice—but to avoid the even greater expenses of taking the suit to court. Sometimes this is even done without the consent of, or notice to, the physician.

Although your bill allows for the comparison of physicians to their peers within their state, it still fails to evaluate the differences in patient population and level of risk associated with the physician's practice. The legislation also fails to recognize the differences in the litigation environment between rural and urban areas. To illustrate this point I would like to share the experience of one of our members. The AOA and the Kansas Association of Osteopathic Medicine recently filed a brief of *Amici Curiae* in the Kansas Court of Appeals on behalf of an osteopathic physician licensed to practice in the State of Kansas (*Miller v. Sloan, Listrom, et al.*, District Case # 95-CV-328). This lawsuit concerned the settlement of a medical malpractice claim by an insurer without the physician's knowledge or consent. In accordance with federal laws and regulations, the settlement then was reported to the National Practitioner Data Bank, where the report now stands as a permanent part of the physician's record.

Because a malpractice settlement was made without the physician's knowledge or consent, he had no opportunity to contest the settlement, deny his liability or explain to the NPDB his belief that he did nothing wrong when treating the patient. In fact, the doctor only learned of the settlement through the National Practitioner Data Bank, where the report has become a permanent scar on the doctor's record.

The harm created by the misleading entry concerning a malpractice settlement is very real. Now, whenever this doctor applies for a position or clinical privileges on a hospital's medical staff—at any hospital in the United States—that hospital is legally required to request information concerning the physician from the Data Bank and, thus, will learn of the settlement and consider it in connection with his application. As such, the physician's ability to secure positions at other hospitals in Kansas and elsewhere in the United States is severely damaged.

In many cases, a malpractice settlement or judgement simply is not a good barometer for quality of care. A study published in *The New England Journal of Medicine* (December 26, 1996—Vol. 335, No. 26) showed that among the malpractice claims, "the severity of the patient's disability, not the occurrence of an adverse event or an adverse event due to negligence, was predictive of payment to the plaintiff."

The *Rand Health Law Issue Paper* of July 1999 (*A Flood of Litigation? Predicting the Consequences of Changing Legal Remedies Available to ERISA Beneficiaries*; Carole Roan Gresenz, Deborah R. Hensler, David M. Studdert, Bonnie Dombey-Moore, Nicholas M. Pace, *A Rand Health Law Issue Paper*, July 1999) stated that several studies have reviewed medical malpractice claims files to determine the relative frequency of appropriate and inappropriate suits and found that between half and two-thirds of claims are brought with no apparent indication of negligence" (Harvard, 1990; Cheney et al., 1989; Farber and White, 1991; McNulty, 1989).

3. PUBLIC DISCLOSURE OF THE INFORMATION HELD IN THE NPDB ELIMINATES THE ROLE OF STATE LICENSURE BOARDS AND OVERRIDES THE EFFORTS OF MANY STATE PROGRAMS ALREADY IN OPERATION.

The AOA supports the scope and authority of state licensure boards and believes that these entities are best suited to determine the competency of physicians, dentists and other health care providers. The use of state licensure boards allows for true “peer review” to be used in an effective manner and insures that all the qualifications of the provider in question are adequately evaluated. The NPDB is a resource for state licensing boards, hospitals and other health care entities in conducting investigations into the qualifications of practitioners they seek to license or hire or to whom they wish to grant membership or clinical privileges.

The Data Bank information should be considered with other relevant information by these entities in evaluating a practitioner’s credentials. While the intent of the NPDB is to track negligent practitioners, the information currently housed in the data bank is often not appropriate for that purpose and, under no circumstances, suited for public interpretation. The use of misleading and often negative information by hospitals and insurers damages physicians’ careers. Your legislation also would eliminate the need for state programs such as the one in Massachusetts, which were designed to provide the public information on physicians within their state. The AOA believes that state licensure boards are better suited to provide the public with the information regarding the physicians in their state.

4. THE NPDB DOES NOT PROVIDE THE PRACTITIONER AN ADEQUATE RIGHT TO RECOURSE.

Currently, practitioners may not submit changes to reports. The practitioner must contact the reporting entity to request corrections. A practitioner may add a statement to the report and/or dispute either the factual accuracy or whether the report was submitted in accordance with NPDB reporting requirements. The practitioner may also request that the Secretary of Health and Human Services review the issues, if the practitioner and reporting entity cannot resolve the issues in dispute.

Mr. Chairman, your bill attempts to eliminate this issue, but it fails to provide adequate recourse for physicians. H.R. 5122 fails specifically to provide the amount of explanatory material a physician will be able to submit on a specific case. Also, a statement submitted by a physician is not a sufficient means of explaining the details of complex medical procedures. The public does not have the scientific and medical background to understand such details. We also feel that many individuals will fail to consider the explanatory information when evaluating their physician and will simply rely upon medical malpractice claims.

Hospitals and other eligible health care entities must report professional review actions that may restrict or revoke a practitioner’s clinical privileges due to issues related to conduct or competence. Professional societies are also required to report specific information when any professional review action due to professional competence or conduct adversely affects the membership of the practitioner. These entities should be given legal liability protections when reporting negligent or incompetent providers. Currently, these entities are subject to litigation when they report or discipline providers, making them hesitant to file such reports or take disciplinary actions.

One small-town New Mexico physician was reported to the Data Bank after her obstetrical privileges were revoked. She reported that she could not relocate because of the Data Bank entry. Notably, that physician sued those responsible for making the Data Bank report on a number of theories, including defamation. She obtained a favorable jury verdict. On appeal, the court found that sufficient evidence was presented for a jury to have concluded the physician suffered impairment of reputation and standing in the community, when she applied for privileges at a new hospital and had to explain why her privileges had been revoked by the reporting hospital. Significantly, though the physician was ultimately granted privileges at the new hospital, the Court did not feel that the physician’s damage claim was undermined since: “an opportunity for rebuttal seldom suffices to undo harm [sic] of defamatory falsehood.”

5. FAILURE TO ADDRESS THE PROBLEMS ASSOCIATED WITH THE USE OF A “CORPORATE SHIELD.”

Another problem that has arisen is what is termed the “corporate shield.” This refers to those instances where an individual health care practitioner’s name is removed from a case, usually during the settlement process, and replaced with some corporate entity. When this occurs, even though a settlement was made, no report

is filed to the NPDB. Removing a person's name for the sole purpose of hiding that individual is illegal under the original statute under which the NPDB was created (the Health Quality Improvement Act of 1986). To address this issue, the Health Resources and Services Administration (HRSA) published a proposed rule on December 24, 1998. HRSA defines the goal of the proposed change to be "to prevent the evasion of Data Bank medical malpractice reporting requirements." The proposed rule describes instances "in which a plaintiff in a malpractice action has agreed to dismiss a defendant health care practitioner from a proceeding, leaving or substituting a hospital or other corporate entity as defendant, at least in part for the purpose of allowing the practitioner to avoid having to report on a malpractice payment made on his or her behalf submitted to the Data Bank." In this circumstance, this "corporate shield" allows for no report to be filed with NPDB.

The AOA agrees with HRSA that this "evasion of the reporting requirement" is wrong. However, the remedy that HRSA proposes is equally wrong. It contains numerous factual, legal, and practical shortcomings. Among the problems are:

A. Failure to make any effort to create a factual record to document the existence and scope, if any, of the so-called "corporate shield" problem.

According to HRSA, the Department of Health and Human Services (DHHS) is aware of efforts to evade the reporting requirements, especially with respect to self-insured entities. However, no effort was made to document this assertion. As a member of the NPDB Executive Committee, I participate regularly in the Committee meetings. Audit results, studies, or other evidence of the existence or extent of the "corporate shield" problem was not reported during any of the meetings I attended.

B. Lack of statutory authority to expand the reporting requirements beyond those set forth in the Health Care Quality Improvement Act.

HRSA's plan would expand the reporting requirement beyond the name of "any physician or licensed health care practitioner, for whose benefit the payment was made," which is provided for by Congress in the Health Care Quality Improvement Act. In place of this narrow mandate, the proposed rule would make it the "responsibility of the payer, during the course of its review of the merits of the claim, to identify any practitioner whose professional conduct was at issue in that malpractice action or claim that resulted in a payment, and report that practitioner to the Data Bank." [emphasis added] This rule far exceeds the statutory authority delegated by Congress.

C. Imposition of substantial administrative burdens and costs on health care providers and their insurers which will ultimately be passed on to health care consumers.

The requirement that the payer identify any practitioners whose conduct was at issue would impose investigative and claim costs far beyond those currently incurred by insurers in processing medical malpractice claims. The proposal would require the payer to identify each health care entity with which the practitioner is affiliated. This would include any managed care organization, group practice, clinic, medical society or other group that provides health care services and engages in a peer review process. In addition, the payer also would have to identify all practitioners who might be involved in the claim.

If this requirement were imposed, a significant administrative burden would be added to those already in existence for the payer. Cost of health care and medical liability insurance would undoubtedly increase, and ultimately be passed onto the consumer.

D. Lack of fairness and due process involved in reporting practitioners.

Serious fairness and due process concerns are raised by the requirement that payers report any practitioner whose conduct was at issue, regardless of whether or not that practitioner was actually named in the claim. Attention must be given to the adverse impact a report to the Data Bank may have on a health care provider's career and reputation.

The American Osteopathic Association, along with a large number of other organizations, brought this issue to the attention of the DHHS General Counsel, Harriet S. Rabb, and HRSA Administrator, Claude E. Fox, M.D., M.P.H. at a September 29, 1999 meeting. Dr. Fox said that HRSA would withdraw the December 24, 1998 NPDB proposal. However, to date no withdrawal notice has been published in the *Federal Register*, so the proposal has yet to be formally withdrawn.

6. THE PATIENT PROTECTION ACT OF 2000 LACKS TRUE PEER REVIEW AND IS INADEQUATE FOR PUBLIC EDUCATION AND INFORMATION.

While the AOA does not oppose a federal data bank open to the public, H.R. 5122 does not provide contextual information that has undergone true peer review. Negligent practitioners can be identified through true peer review, to-wit: when a professional organization, licensing board or true peer review organization (comprised of physicians of same license and specialty) rules that a practitioner has been negligent in his/her performance of patient care, the public has a right to know. But I emphasize that before any information is made public; it must pass the test of true peer review. Unfortunately, the Patient Protection Act of 2000 does not utilize this key element of physician evaluation and therefore we feel that the information is not suitable for public interpretation of a physician's competency. State medical and licensure boards need to do a better job of sharing information between different states. These common sense and simple solutions would go a long way toward weeding out truly negligent and incompetent physicians.

The NPDB has serious flaws, which make it inadequate for the purpose it is meant to fulfill. I encourage each of you to consider carefully the issues presented today. I also would like to highlight testimony submitted on March 16, 2000 by Thomas Croft, the Director of the Division of Quality Assurance, Bureau of Health Professions, Health Resources and Service Administration, when he testified before the House Commerce Subcommittee on Oversight and Investigations. As you know, Mr. Croft is the Director of the Division that oversees the operation of the NPDB.

Mr. Croft made two very strong points. First, *"Nothing in the Data Bank's information, on the other hand, is intended to produce and independent determination about the competency of an individual practitioner. It rather is intended to supplement a comprehensive and careful peer review."* He later quoted Secretary Shalala that *"...there are privacy concerns regarding broad public disclosure of potentially incomplete negative information."* I bring these statements to your attention to illustrate that even the individual who is responsible and most knowledgeable about the National Practitioner Data Bank is opposed not only to the public disclosure of the NPDB's information, but also to the NPDB being utilized as the only source of information when evaluating a physician's competency.

CONCLUSION

In closing, Americans have a right to the best medical care possible and physicians have a right to be treated fairly when under review by the public, government agencies, review boards, hospitals and their peers.

Mr. Chairman, the public would be better served by more than just misleading physician malpractice information. For instance, information regarding a physician's education, training, insurance plan participation, and hospitals of practicing rights would be useful and appropriate for public access. The sole purpose of your legislation is clearly the public dissemination of medical malpractice information and seems suspiciously anti-physician rather than pro-patient. I encourage you to reconsider carefully your position regarding this issue and to re-examine the propriety, usefulness, and accuracy of the NPDB information you seek to make available to the public.

Also, the AOA has serious concerns regarding both the timing of H.R. 5122 and the title of the bill. A heated debate is occurring on Capitol Hill regarding the Patients' Bill of Rights, with numerous versions being called a "Patient Protection Act." The two issues should not be confused, nor should the Patients' Bill of Rights be forgotten or lost in the shuffle of a last minute legislative free-for-all in the waning days of the 106th Congress. I respectfully request you use your leadership position as a managed care conferee to pass a meaningful, comprehensive and true Patients' Bill of Rights before Congress adjourns. Those are the real protections our patients need and deserve.

Thank you for the opportunity to testify today. The AOA stands ready to participate in a bipartisan effort to develop a public data bank that will truly provide consumer protection.

Mr. BILIRAKIS. Thank you very much, Doctor.
Ms. Weintraub, please proceed.

STATEMENT OF RACHEL WEINTRAUB

Ms. WEINTRAUB. Thank you.

Mr. Bilirakis and members of the Commerce Committee, good afternoon; and thank you for giving me the opportunity to address you today. My name is Rachel Weintraub. I am a staff attorney for the U.S. Public Interest Research Group. The U.S. PIRG and the State Public Interest Research Groups applaud Chairman Bliley's introduction of H.R. 5122, the Patient Protection Act of 2000. This legislation assures that consumers will have access to critical information about their doctors such as disciplinary and medical malpractice payment information.

This information already exists and is accessible to managed care plans and insurance companies at taxpayer expense. The PIRGs have supported strong physician profiling laws in a number of States. However, even strong State laws are limited in their ability to provide consumers with information from the 49 other States.

Consumers looking for a physician currently have far less relevant information about their physician's capability and experience than they would if looking to purchase a car, a VCR or almost any other consumer product. Consumers regularly comparative shop. Over 4 million consumers subscribe to Consumer Reports to help them make informed decisions about the products they wish to purchase. However, health care consumers are forced to rely on word of mouth, personal anecdotes or, most typically, random chance to make crucial decisions about their health care providers.

In response to the lack of information available to the public about their doctors and consistent support of consumers right to know, the State PIRGs have supported strong State laws that provide patients with the critical information they need to evaluate their physicians capability. In 1996, the Massachusetts Public Interest Research Group successfully advocated to pass the Physician Disclosure bill. This law upon which H.R. 5122 is partially based requires the State board of registration and medicine to compile individual profiles on each licensed physician in the State and make this information available to the public through an 800 number as well as the Internet.

The Massachusetts law was embraced by consumers, as well that State's medical society, the publishers of the prestigious New England Journal of Medicine. A Massachusetts Medical Society news release stated, we see this bill as a win-win situation for patients as well as physicians.

In New York, the New York Public Interest Research Group has worked to pass the physician profiling law that overwhelmingly passed both Houses and is now sitting on the Governor's desk. In New York the passage of the physician profiling law is critical because the information is already collected by the State using taxpayer dollars but consumers are excluded from using this information. Moreover a significant bipartisan majority supported passage of the legislation in the State assembly and the Senate, and a large and diverse coalition of New York State organizations have supported this legislation.

According to a Zogby poll released May 10 of this year, over 90 percent of New Yorkers want easy access to physicians' medical malpractice histories. The coalition of almost 40 civic, consumer, patients rights, small business and senior groups urge the passage

of Lisa's Law, which would allow easy access to physicians' medical malpractice experience.

Lisa's Law is named after the late Lisa Smart who died during an unsuccessful surgery in a New York hospital. The Smart family has argued that had Lisa known of her physician's malpractice problems she would not have agreed to the surgery and would be alive today. Unfortunately, in New York, the State Medical Association was not one of the almost 40 organizations supporting this important legislation and has actively worked to weaken and to defeat Lisa's Law.

In addition to the difficulty in passing strong patient right-to-know laws, State laws include varying types and formats of information; and some States have no publicly available data bases at all, leaving millions of Americans with no information about their doctors. Most significant is the incredible administrative burden for States to obtain disciplinary information from the 49 other States in different formats with different criteria.

Opening up the National Practitioner Data Bank, which already compiles this information, will ease the administrative difficulties of the States and provide consumers with complete information. A Federal law will also provide a floor model for State data bases, while allowing States to expand upon the information provided in the National Practitioner Data Bank.

While opening the National Practitioner Data Bank to consumers will be a critically important tool, we suggest an improvement that will make the National Practitioner Data Bank even more useful to consumers.

In H.R. 5122, the method prescribed for obtaining the information contained in the National Practitioner Data Bank is limited exclusively to the Internet. The Internet should be just one means of communicating this information. Many people don't own computers. The digital divide obligates the development of noncomputer means for people to learn about their physicians.

We suggest that H.R. 5122 also require the establishment of a public 800 number hotline. The 800 number facility should also provide fax and mail service for consumers who are seeking information. The National Practitioner Data Bank currently has an 800 number. This 800 number should be made available to the public, just as it is now available to those who currently have access to the National Practitioner Data Bank.

The introduction of H.R. 5122 by Chairman Bliley signals an important change in our approach to health care. We applaud Chairman Bliley for recognizing that consumers need ready access to objective, comprehensive and understandable information to make more intelligent choices among providers and to ask pertinent questions of the providers they do choose.

I look forward to working with Chairman Bliley and the members of the committee to ensure the enactment of this important legislation. Thank you.

[The prepared statement of Rachel Weintraub follows:]

PREPARED STATEMENT OF RACHEL WEINTRAUB, STAFF ATTORNEY, U.S. PUBLIC
INTEREST RESEARCH GROUP

I. INTRODUCTION

Chairman Bliley, Congressman Dingell and members of the Commerce Committee. Good morning and thank you for giving me the opportunity to address you today. My name is Rachel Weintraub. I am a staff attorney for the United States Public Interest Research Group. U.S. PIRG is the national lobbying office for state-based Public Interest Research Groups across the country. The state PIRGs are independent, non-profit, non-partisan public interest advocacy organizations.

II. SUMMARY OF U.S. PIRG'S POSITION

U.S. PIRG and the State Public Interest Research Groups applaud Chairman Bliley's introduction of H.R. 5122, the Patient Protection Act of 2000. This legislation assures that consumers will have access to critical information about their doctors such as disciplinary and medical malpractice payment information. This information already exists and is accessible to managed care plans and insurance companies at taxpayer expense. The PIRGs have supported strong physician profiling laws in a number of states. However, even strong state laws are limited in their ability to provide consumers with information from the forty-nine other states.

III. H.R. 5122, THE PATIENT PROTECTION ACT OF 2000 IS NECESSARY

In December 1999, the National Academy of Science's Institute of Medicine released an alarming study that revealed that as many as 98,000 people die each year in hospitals because of medical errors.¹ Yet, Sidney Wolfe, Director of Public Citizen's Health Research Group, in his book, "*20,215 Questionable Doctors*" states that only a fraction of substandard doctors are penalized by state medical boards. By combining state board actions with other critical information, the National Practitioner Data Bank offers the most complete and comprehensive information available.

Consumers looking for a physician currently have far less relevant information about their physicians' capability and experience than they would if looking to purchase a car, a VCR or almost any other consumer product. Consumers regularly comparative shop. Over 4 million consumers subscribe to *Consumer Reports* to help them make informed decisions about the products they wish to purchase. However, health care consumers are forced to rely on word of mouth, personal anecdotes or, most typically, random chance to make crucial decisions about their health care providers. A cancer patient deciding who should perform his surgery or a pregnant woman uncertain whether to have her baby delivered at a local hospital have no resource to provide them with the critical information they need to make an educated decision.

A. State Public Interest Research Group Advocacy for State Laws

In response to the high rate of medical errors, the lack of information available to the public about their doctors, and support of consumers' "right to know," the State PIRGs have supported strong state laws that provide patients with the critical information they need to evaluate their physicians' capability.

In 1996, the Massachusetts Public Interest Research Group successfully advocated to pass "The Physician Disclosure Bill." The Physician Disclosure Bill, upon which H.R. 5122 is partially based, requires the state Board of Registration in Medicine to compile individual profiles on each licensed physician in the state, and make this information available to the public through an "800" number and the internet. The information in the profiles includes a description of any criminal convictions for felonies or serious misdemeanors, any disciplinary actions taken by the Massachusetts Board of Registration in Medicine or by Boards in any other state in the last ten years, any revocation or involuntary restrictions of hospital privileges in the last ten years, medical malpractice judgments or settlements in which a payment was awarded, and the educational background of the physician. The Massachusetts law was embraced by consumers, as well as that state's medical society, the publishers of the prestigious New England Journal of Medicine. A Massachusetts Medical Society news release stated: "we see this bill as a 'win-win' situation for patients and physicians."²

¹Institute of Medicine, *To Err is Human: Building a Safer Health System*, page 1, December 1999.

²Massachusetts Medical Society News Release, August 1, 1996.

In hearings before the Commerce Committee's Subcommittee on Oversight and Investigations on March 1, 2000, the Executive Director of the Board of Registration in Medicine, Commonwealth of Massachusetts, Ms. Nancy Achin Sullivan, stated that the Massachusetts law has been a "tremendous success."³ She noted that since the law was enacted in November of 1996, nearly 4.9 million profiles have been accessed by consumers, but physicians have not left the state nor been victims of frivolous lawsuits. "In fact," Ms. Sullivan stated, "the Massachusetts rate for malpractice payments has actually decreased...by 12.36%."⁴ Thus, the law in Massachusetts has helped to inform millions of consumers without harming physicians.

In New York, the New York Public Interest Research Group has worked to pass the physician profiling law that overwhelmingly passed both houses and is now sitting on the Governor's desk. This law would include a statement of a physician's criminal convictions occurring in the state in the past ten years, a statement of disciplinary actions, a statement of practice limitations, a statement relating to the malpractice history of the physician, and statements describing the physician's educational and professional background. In New York, NYPIRG believed that passage of a physician profiling law was critical because the information is already collected by the state using taxpayer dollars. Moreover, a significant bi-partisan majority supported passage of the legislation in the state Assembly and the Senate, and a large and diverse coalition of New York state organizations have supported this legislation. Unfortunately, in New York, the state medical association was not one of the over forty organizations supporting this important legislation.

B. Inherent Limitations of State Laws

Currently, different states have laws requiring the inclusion of different types of information, and some states have no publicly available data bases at all, leaving millions of Americans with no information about their doctors. States define "data bases" differently. For example not all states include malpractice information or criminal convictions. Most significant is the incredible administrative burden for states to obtain disciplinary information from the forty-nine other states in different formats with different criteria. The Massachusetts law requires inclusion of disciplinary actions from other state boards. However, out of state information has proven difficult to obtain. Opening up the National Practitioner Data Bank, which already compiles this information, will ease the administrative difficulties of the states and provide consumers with complete information. A Federal law will also provide a "floor" model for state data bases while allowing states to expand upon the information provided in the National Practitioner Data Bank.

C. Important Provisions of H.R. 5122

The physician information available to the public must be both (1) meaningful for consumers, and (2) fair to physicians. There is no conflict between these goals, and H.R. 5122 accomplishes them both. To be "meaningful," information must be relevant to a consumers' choice of physician, and be presented in a format that can be easily understood by the lay person. To be "fair" to physicians, profile information must be complete. Without full reporting and collection of data, some doctors will appear better than others simply because negative information has not been reported. Making this information available to the public will encourage the physician community to throw its weight behind efforts to achieve full reporting.

Critical information that passage of H.R. 5122 will make available to consumers includes full reports on medical malpractice payments, reports of sanctions taken by boards of medical examiners, criminal acts of physicians, felony convictions and misdemeanor convictions of physicians in the Secretary's discretion that may reflect on quality health matters, and the reports of certain professional review actions taken by health care entities. This information provided in a clear and comprehensive manner will give consumers the tools they need to intelligently evaluate their physicians capabilities.

All information will be presented in the proper context. Thus, for example, malpractice claims information for an individual physician will include a comparison with data for a typical practitioner in that specialty. H.R. 5122 makes this information available as a side-by-side comparison of a physician's malpractice and disciplinary history with that of a typical practitioner in that specialty. This underlying information presented properly will enable consumers to make their own comparisons

³*Public Access to the National Practitioner Data Bank: What Consumers Should Know About Their Doctors, Hearings Before the Subcomm. On Oversight and Investigations of the House Commerce Comm.*, 106th Cong. (March 1, 1999) (statement of Nancy Achin Sullivan, Executive Director of the Board of Registration in Medicine, Commonwealth of Massachusetts).

⁴*Id.*

and draw their own conclusions. The number of suits filed, settled and adjudicated needs to be provided to consumers in the context of comparative norms for each specialty. Thus, one or two claims over a number of years of practice may or may not be a cause for concern; if, as physicians often claim, everyone gets sued, this will quickly become apparent to consumers and will not be unduly prejudicial (unless the number of claims against a particular doctor is unusually high).

IV. SUGGESTED IMPROVEMENTS OF H.R. 5122

While opening the National Practitioner Data Bank to consumers will be a critically important tool, we suggest some improvements that will make the National Practitioner Data Bank even more useful to consumers. In section 101(c) of H.R. 5122, the method proscribed for obtaining the information contained in the National Practitioner Data Bank is limited exclusively to the internet. The internet should be just one means of communicating this information. Many people don't own computers. This digital divide obligates the development of non-computer means for people to learn about their physicians. We suggest that H.R. 5122 also require the establishment of a public "800" number hotline. The "800" number facility should also provide same day fax and mail services for consumers who are seeking information. The National Practitioner Data Bank currently has an "800" number. This "800" number should be made available to the public just as it is now available to those who currently have access to the National Practitioner Data Bank.

We also urge you to consider expanding the reporting requirements to include nurse practitioners and physician assistants who in managed care settings often deliver care to patients. At a minimum, the bill should specify who is covered under the definition of a physician. In addition, we urge you to provide an opportunity for consumers or an individual acting on their behalf to submit a statement regarding the information reported in order to provide balance since providers are afforded this same opportunity.

V. CONCLUSION

H.R. 5122, The Patient Protection Act of 2000, will provide patients with much of the critical information they need to make informed decisions when choosing a doctor. Opening the National Practitioner Data Bank will make disciplinary and medical malpractice payment information about physicians available to the public in a comprehensive, clear and objective manner. Health care consumers are at long last on the brink of gaining ready access to information about physician competence and qualifications.

The introduction of H.R. 5122 by Chairman Bliley signals an important change in our approach to health care. We applaud Chairman Bliley for recognizing that consumers need ready access to objective, comprehensive and understandable information to make more intelligent choices among providers and to ask pertinent questions of the providers they do choose. I look forward to working with Chairman Bliley, Mr. Dingell and the members of the Commerce Committee to ensure the enactment of this important legislation.

Chairman BLILEY. Thank you very much.

The Chair recognizes himself for 5 minutes.

In your testimony, Dr. Corlin, you praised the Federation of State Medical Boards' All Licensed Physicians Project. What you did not mention was that a fee would be charged for access to their Data Bank, and the FSMB project is woefully incomplete as it does not include hospital disciplinary information or medical malpractice information. Do you believe that the American consumer should have to pay for the limited information in the FSMB Data Bank?

Mr. CORLIN. Mr. Bliley, you raise two issues there; and let me deal with them separately. One is the issue of a fee; and separate, second, is the issue of the adequacy of the information.

If there is going to be a system developed modelled from the financial standpoint—and I am only talking now about financial aspect of it the way the National Practitioner Data Bank is, which is user supported—there is going to have to be a fee involved, just as there is a fee to every organization that now queries the Data Bank to get its information. If there is a proposal to open the Na-

tional Practitioner Data Bank or any other Data Bank, federated, State medical bank or others, if it is not supported with user fees there has to be a very substantial government subsidy to support that. And that is a question that you collectively will have to deal with far more than we collectively have to deal with down here.

Second, with regard to the data that should be available, we believe very strongly that all disciplinary actions should be included in the report. We are very comfortable with malpractice reporting modelled after the way they are in the Massachusetts system, which is very different from the system which is being proposed here.

Chairman BLILEY. In your testimony you stated that congressional drafters of the legislation in 1986 felt the Data Bank was not the mechanism upon which to provide patients with the information about the overall qualification of physicians. I am sure you are aware of Senator Ron Wyden's important role in the initial legislation. I think we can describe him as the primary force pushing the legislation in 1986.

Are you aware that he testified at our first hearing on this matter and said: "First, there is no logical argument for keeping information about proven, flagrant cases of professional misconduct from the public. For the Federal Government to refuse to disclose important information in the Data Bank about physician misconduct just doesn't pass the smell test."

For the record, is it not the case that the primary drafter of the National Practitioner Data Bank legislation is in favor of opening the Data Bank?

Mr. CORLIN. Mr. Wyden, even prior to the time when he was a senator, has always been in favor of that; and I can remember times back in the 1980's when I was an officer of the State Medical Association, we met with him and he expressed that then. That has always been his opinion, yes.

The issue is not withholding information about misconduct by physicians. The issue is, what is the form of that information? What does it mean?

Let me give you an example. If you were to, as Mr. Inlander pointed out, be legally able to query the Data Bank about a Richard F. Corlin of Santa Monica, California, you would come up with a \$55,000 settlement in a malpractice case. That was a case during a colonoscopy that I was doing when the instrument fell apart inside the patient and could not be retrieved, and the instrument—the patient had to be operated on to get that piece of the instrument out. That was not medical malpractice on my part. That was poor quality control on the part of a company in Japan that made the instrument, yet in the Data Bank it is listed as a \$55,000 judgment against me. I don't think that that patient seeing that would get the right impression by reading those few lines.

Chairman BLILEY. I have very little time left, but I would like to ask this last question: Is it not the official position of the AMA to abolish the National Practitioner Data Bank, even as it currently operates with limited access to professionals?

Mr. CORLIN. Give me a moment, sir. Let me see if I can get our exact policy on that.

It is our position that completion of the Federation of State Medical Boards' Data Bank and the amplification of it will serve the public better; and we would prefer to see that instead of the Data Bank as it exists now.

Chairman BLILEY. So the answer to my question is yes.

Mr. CORLIN. Yes, but not just, yes, not abolishing it and leaving no data available—abolishing it and leaving what we believe to be better data available.

Chairman BLILEY. We have a difference of opinion about that.

My time is expired. The Chair now recognizes the gentleman from Ohio, Mr. Strickland.

Mr. STRICKLAND. Thank you, Mr. Chairman.

Dr. Loniewski, looking at this bill, it seems to suggest that in its present form significant information to be released about practitioners could allow consumers to draw wrongful conclusions—and I think your example that you just pointed out substantiates what I am trying to get at here—and unfairly reject the use of highly qualified, competent doctors. Am I correct in predicting that as a possible outcome?

Mr. LONIEWSKI. Are you addressing me? You are looking—

Mr. STRICKLAND. Yes, I am sorry.

Mr. LONIEWSKI. Yes.

Mr. STRICKLAND. Dr. Hochman, would you agree with that assessment?

Mr. HOCHMAN. I would.

Mr. STRICKLAND. Dr. Corlin?

Mr. CORLIN. Yes, sir.

Mr. STRICKLAND. Dr. Loniewski, am I correct in my view that another significant concern regarding this bill is that, while it attempts to compare certain malpractice data across statistical categories, it still does not place all malpractice issues into proper context? For example, it doesn't adequately explain malpractice cases, such as when a doctor has more than one specialty, when a doctor chooses to work uniquely high-risk procedures or even when a doctor chooses to work with high-risk patients. Is that a reasonable view of this legislation?

Mr. LONIEWSKI. Yes, it is. But you have got to realize that you have got to be able to compare apples against apples, and when you are talking about specialties also there are certain specialties in your profession that are certainly much higher risk that have to be compared.

Likewise, in the areas that they are from, the laws differ from State to State in the way they deal with malpractice; and that has a great bearing on how you can compare this. That is why you have to take it into consideration. So looking at it peer reviews at a State level would give us much better information to the public.

Mr. STRICKLAND. Thank you, sir.

Dr. Hochman, do you agree with that?

Mr. HOCHMAN. I would agree. The complexity that we face sometimes when we as physicians as a group look over the medical malpractice data, it is very difficult; and a lot of times we have questions even amongst ourselves as we look through that data.

Mr. STRICKLAND. And Dr. Corlin.

Mr. CORLIN. Yes, I would.

Another factor leading into the correctness of your statement, Mr. Strickland, is that the circumstances in which malpractice suits are brought and the limits on payments of them or lack of limits differ from State to State. So that if you compare one doctor to another doctor, you may get different information that doesn't relate to the severity of the issue but the environment.

Now if somebody is in Santa Monica, they are not likely to be practicing in another State. But if you get somebody in Kansas, Missouri, or other States, that can be across State lines; and those can be factors.

Mr. STRICKLAND. If I could ask you, if you could, to answer a series of questions, just a yes or no, if that is a sufficient way to express your opinion.

Dr. Loniewski, there seems to be little in this bill that would directly help the States' efforts in their attempt to develop their own physician profiling systems or any effort to link those systems into a unified data base. Is that a fair assessment, in your opinion?

Mr. LONIEWSKI. Yes, it is.

Mr. STRICKLAND. Dr. Hochman?

Mr. HOCHMAN. Yes.

Mr. STRICKLAND. Dr. Corlin?

Mr. CORLIN. Yes, sir.

Mr. STRICKLAND. Dr. Corlin, would you believe it to be fair to say that, given the appropriate resources, the States could devise a State-based, linked system that might surpass the quality of a Federal system in tracking questionable doctors?

Mr. CORLIN. Yes.

Mr. STRICKLAND. Dr. Hochman, do you agree?

Mr. HOCHMAN. Yes.

Mr. STRICKLAND. Dr. Loniewski, as I read the bill, the bill would allow a physician reported in the Data Bank to submit only a 4,000 character statement to describe the details of a complex medical procedure or a malpractice case. In light of this, do you think it is fair to describe this bill as not providing the practitioner with an adequate method of recourse to the NPDB?

Mr. LONIEWSKI. I couldn't say that any better.

Mr. STRICKLAND. Dr. Hochman?

Mr. HOCHMAN. Correct, I agree.

Mr. STRICKLAND. Dr. Corlin?

Mr. CORLIN. Yes.

Mr. STRICKLAND. Dr. Corlin, is it also fair to say that this bill will remove the user fee financing that the NPDB has mostly relied upon since its inception and that this new Federal program envisioned by this legislation will require direct financing by the U.S. taxpayer? Do you think that is a correct assessment?

Mr. CORLIN. That is our belief, yes.

Mr. STRICKLAND. Dr. Hochman?

Mr. HOCHMAN. I agree.

Mr. STRICKLAND. Dr. Loniewski?

Mr. LONIEWSKI. I agree, yes.

Mr. STRICKLAND. Dr. Corlin, would I also be correct in assuming that nobody at this point knows what this system costs because it is yet to be scored by the Congressional Budget Office or the OMB?

Mr. CORLIN. That is correct. And if I can add one sentence more. It is yet to be scored, and also we have significant experience going beyond what their score is costing.

Mr. STRICKLAND. My time is up. I would just like to say that we had two hearings on this issue before the Oversight and Investigations Subcommittee, of which I am a member. I think all of us are concerned about the issues raised, but we need to work together in a way that we haven't thus far to come up with reasonable solutions to this very serious problem. Thank you very much.

Chairman BLILEY. The gentleman from Florida, Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

I think it was Dr. Hochman who made the comment—it might have been Dr. Loniewski—that you were supportive of a National Data Bank and—as is the group you represent, the American Osteopathic Association, provided that the bank reflects the accuracy of the information. You talked about possible peer review analysis by the various State organizations. Very briefly, maybe you can go into that in more detail, just very briefly?

Mr. LONIEWSKI. Yes. What I was saying was we would be in favor of a Data Bank that had true peer review. By true peer review we mean where the professional organization can review with the same type of licensee, same type of specialty so they can have a feeling for what the problem is and judge that physician as being competent or incompetent.

Mr. BILIRAKIS. Okay, Dr. Hochman, would your group be supportive of that?

Mr. HOCHMAN. My comment would be the whole area of what information is best for the consumer is something that needs much more work. If it was as simple as opening up the National Practitioner Data Bank and making these egregious cases go away, that would be easy; and I think the issue of what information is available is something that needs more study.

Mr. BILIRAKIS. But the tests, so to speak, that Dr. Loniewski refers to makes sense to you.

Mr. HOCHMAN. Some of it, but we would have to review some of those issues.

Mr. BILIRAKIS. Dr. Corlin, you knew I wasn't going to pass you up.

Mr. CORLIN. Yes, I would agree with that. I think we need peer review answerable to public standards. But you can't leave the peer review out of it, and it is our impression that this bill would leave the peer review out of it.

Mr. BILIRAKIS. All right, and if that peer review, in whatever form it were to take place, were in a true, legitimate, fair form, would that be a good, disinterested, unbiased peer review—you know, assuming that much of the peer review group would consist of physicians?

Mr. CORLIN. It would have to be; and it would have to be a group that, by its composition and by its conduct, had the confidence of the disinterested public.

Mr. BILIRAKIS. You feel that is doable?

Mr. CORLIN. It is doable. It can be done wrong, but it is doable to do it right.

Mr. BILIRAKIS. And if that were to take place, a National Data Bank would not necessarily then be a bad thing.

Mr. CORLIN. If the data in it were right and peer reviewed, no, it would not be a bad thing.

Mr. BILIRAKIS. Sir, let me ask you, with all due respect, you have appeared before my committee a number of times. Mr. Stewart's written testimony states that a convicted judge contacted the AMA to prevent him, Dr. Swango, from practicing medicine. Was the AMA unwilling to stop that convicted felon from practicing medicine? And if they were, why?

Mr. CORLIN. The answer is, no, we were not unwilling to stop him. I wish we had the legal authority to do that.

There was a time, a long time ago, where you had to be a AMA member to have hospital staff privileges. That was decades ago, and that has long since gone. The only thing the AMA can do is exclude somebody from membership.

Dr. Swango was never a member of the AMA. He had applied for membership, but very, very shortly after he applied he withdrew his application. And I don't as I sit here know if it was because he decided to do it or there were questions raised. I don't know specifically, but I do know that was the circumstances of the entire Swango situation.

Mr. BILIRAKIS. I guess you are right, when I think about it. You haven't the authority to maybe stop it, but could you have had the authority to contact the particular State.

Mr. CORLIN. I don't, as I sit here now, Mr. Bilirakis, know exactly—you know, to ask the question, what did we know and when did we know it because I was just briefed on that aspect of things this morning. I can promise you that I will inquire of our legal counsel and get written communication to you and Mr. Bliley that, to the extent there is information available, what was the AMA's both involvement and knowledge of the situation.

Mr. BILIRAKIS. If you would do that, I think it would be helpful, sir. What I am saying is to me it is sort of criminal that a person can have that kind of a background and go to another State and practice medicine. I don't really know what the heck can be done about it, but it seems a lot should be done.

Mr. CORLIN. I absolutely agree with you. I will make a call as soon as we finish and get that information going; and as soon as it can be available it will be faxed to both of you, sir.

Mr. BILIRAKIS. Thank you.

Chairman BLILEY. The time of the gentleman has expired.

The Chair now recognizes the gentleman from Iowa, Dr. Ganske.

Mr. GANSKE. Well, Mr. Chairman, I think as we have listened to our panelists today and the back and forth on the committee, I honestly think that there is some consensus that we could use to work to get better information out to consumers.

Personally, I think there should be a nationally available Data Bank of some type for consumers, paid for by the Federal Government, if necessary. I think it should include the public records of the various State medical societies, licensing boards. I think it should include criminal convictions, Mr. Stewart, particularly as they relate to the practice of medicine. I think that, you know, you could get into a discussion of misdemeanors of, you know, traffic

tickets and things like that, how that would affect one group more than another group in terms of public disclosure.

I think that there would be many areas of agreement on what should be public in Iowa. All of the State Board of Medical Licensure decisions basically appear on the front page of the Des Moines Register, and I certainly don't have a problem with having access to those decisions by the State Board of Licensure in Illinois or Nebraska or anywhere else across the country being gathered together and being available.

The real problem that we have is on the question of settlements, not on judgments—because I think judgments should be in that Data Bank, okay—but on settlements, and that is the problem. Because this is how it works.

The majority of malpractice carriers are publicly held stock companies. Their investors are looking for profits. The physician buys malpractice insurance for a price. This income to the company is invested. The company's expenses are paid; and at the end of each fiscal year dividends are paid, based to some degree on profitability.

The defense of the physician, even in the most righteous of circumstance, is still an expense. Usually, the preparation for the defense takes numerous hours, not only of an experienced lawyer's time but that of numerous paralegals. Expert witnesses must be identified and their testimony taken. Reams of paper are generated at no small cost. Charts are copied and recopied and distributed across the Nation by overnight mail, and the costs mount.

It has been roughly estimated that even an administration of a malpractice suit that does not involve a death will take an average of 4 to 5 days of trial time, with an estimated cost of trial by jury of \$100,000. When the stakes are high, it is not surprising that most defense teams will agree to a reasonable settlement, even when the defense case is strong, when it is clear that the doctor has not committed an infraction, but we can settle this case for \$5,000 or \$10,000, and we are out the door, and the insurance company says, take it or leave it, but if you don't take it you are on your own.

That is a problem, and it seems to the members of the medical profession fundamentally unfair that that then goes reported.

Furthermore, most of those settlements are closed. They are legally closed, so you may not even have a chance to explain your case, your side and whether you were treated fairly or not. Those are business decisions made by insurance companies, and I think it is something we have to take into account as we look at trying to devise information for the consumer out there so that it can be accurate.

Finally, especially, Mr. Plunkett, as a member of the Consumer Federation, I want to point out that managed care companies, the HIAA, the AAHP, NAM and some other groups, have come out strongly in favor of this legislation, Mr. Bliley's legislation. Let me point out to you that they have a conflict of interest, a significant one. Ten days from now, the State of Maryland is going to have to go into law a State law that basically prohibits what are called "cram down contracts" where an insurer says you take all of our products or you don't take any. That was prohibited by the Mary-

land legislature. So what are those HMO goes going to do, they will simply deselect those providers who don't sign all of the contracts.

What is the next response by the State legislatures? To pass a law that says you cannot deselect without cause.

Okay. Mr. Chairman, with your indulgence, 1 more minute to finish my point.

Chairman BLILEY. Without objection.

Mr. GANSKE. Thank you.

What then happens when a State legislature passes the next law to try to prevent insurers from unfairly deselecting providers, bypassing you can't do it without cause? HMOs rub their hands. They say, great, we will do it with cause. We will go into those offices, we will run our finger along the venetian blinds, we will find a couple of dirty coffee cups, we will find some patient that will say something bad about this physician, and then we will deselect him with cause. Guess what? That appears in the National Practitioner Data Bank, and under current rules you have to get permission from the organization that put that in there to take it out.

I think that is one of the unintended consequences that we need to look at. Because I know that your organization has been a strong one in favor of consumer rights and patient protection, and it is something for us to think about in this.

Thank you, Mr. Chairman.

Chairman BLILEY. The Chair now recognizes the gentleman from Tennessee, Mr. Bryant.

Mr. BRYANT. Thank you, Mr. Chairman.

I thought defending malpractice patients was complicated. Certainly we have heard compelling testimony from the first panel and from those on this panel that represent very differing interests on this issue. And it appears—I think our subcommittee chairman, Mike Bilirakis, has indicated there might be some common ground here that is emerging. I don't know.

I do know that, in reading this, studying upon some materials for preparation for this hearing, it appears the original intent of this law was not for it to become public. I know there are statements out there that were argued, but it probably did come into play with the idea that it would be used by professionals in peer group situations. And I understand that one purpose was to encourage reporting, accurate reporting of all the information to this Data Bank, which is a very important part of the whole process.

But as we go through times, times are changing; and we just—not to compare the same thing, but we just sat through hearings a week or so ago on tire situations, on automobiles and what is happening there and disclosure and callbacks and recalls and things like that. But the public—the consumer does demand more. But yet there is a compelling side, I believe, on the medical side to have accurate reporting and to have this peer review and to put things into proper context so that they could be understood. But I am wondering if at some point there couldn't be some common ground found.

In reading Dr. Corlin's testimony, something that strikes me already about this data base is on page eight he talks about the DOD, Department of Defense, and the Department of Veterans Affairs already recognize the serious problems with correlating law-

suits with physicians' competence or negligence. And under their systems, DOD and VA, the physicians aren't reported to the data base when a claim is settled unless a panel of peers actually go back and review and find negligence or incompetence. That is part of the government already setting up this type of standard. They go on to say that roughly they find in their cases only about 30 percent of their settled cases, according to the peer group, comes from actual negligence. The other reasons are—70 percent you would settle a case I suppose. So there is validity on all sides.

Ms. Weintraub, you haven't been asked any questions, and you are an attorney and on the other side from the doctors. I wonder what your comment would be on the comment of the DOD and the Veterans in terms of their correlation and the use a peer group before they submit names to this data base.

Ms. WEINTRAUB. Well, I think this information does not necessarily—the importance of this information is to allow consumers to have the ability to decide for themselves in a comprehensive way how—their doctor's medical histories. There is no clear link and no one has said on this panel that, you know, malpractice claims are always entirely connected to other types of incompetence. Basically, it is just consumers will be able to tell from extensive information and decide for themselves whether they wish to use this provider.

Mr. BRYANT. Let me ask Mr. Inlander on the other end. You are a very forceful advocate for your position. You have been here for years, and nothing has really changed, I understand. Would you agree if we had a data base system, whether it was a State-based or Federal system, if we had the best type, the best quality of information, that the consumers would benefit from that?

Mr. INLANDER. Sure, they do. But the point is, this is the exact same testimony that the late Dr. Todd gave in 1986 before this very committee, saying that the AMA is on the brink of giving us that kind of a system. The State federation says the same thing.

Every State medical society has come, when a physician profiling law has been put before it, and said, we are a year or two away from giving—including in Pennsylvania where they got a law killed because the legislator said we will wait for that year or two until you come back. They have never come back.

So you see at some point we have to draw the line in the sand and say, given the data that we have—and I have got to say the information there is in the Data Bank is not slanderous, it is not innuendo, this is actions taken by the State, by a hospital, by a license board, by a court or by the DEA. This is not just stuff that people filed.

Mr. BRYANT. Let me stop you there.

Mr. INLANDER. I just want to say to you, there are basis of information—

Mr. BRYANT. I want to ask you another question, but I want one of the three—Dr. Corlin or Dr. Hochman or Dr. Loniewski—to respond to that issue. But before you do that, quickly I want to ask Mr. Inlander, do you not think that by making this public that it would have the reverse cause of causing people not to want to report what they are already reporting now under the idea that it is somewhat confidential?

Mr. INLANDER. I don't really think so. Because I don't think there is any evidence that has occurred, for example, in Massachusetts where the law has been effect 4 years. I think you are going to hear that there is no evidence that anything wasn't reported.

I think also we have to look at it in terms of other kinds of disclosure laws that have come about, including those that are upon you to disclose financial information in terms of your lives as congressmen. That same question used to come up at that point in time and when that law was being considered. So I think that there is no evidence to suggest that this is going to happen, and I think until there is we can deal with it, but there is no evidence that anyone supports that position.

Mr. BRYANT. Mr. Chairman, could I have 1 minute with unanimous consent?

Chairman BLILEY. Without objection.

Mr. BRYANT. Very quickly, Dr. Corlin, Dr. Hochman, one of the doctors, could you respond to the statement by Mr. Inlander about the Medical Association promising this and not following through?

Mr. CORLIN. Well, we did not promise that we would produce a system, that is, in every system, ever since the first year somebody suggested maybe we should operate the Data Bank and we didn't we think we could support it. I know that we support the ongoing activity of the Federation of State Medical Boards. My suggestion to you, sir, if you are going to hold another hearing, is ask them to come and let them speak on their own behalf. I think they can be more informative than me relating what they are doing.

Mr. BRYANT. Thank you.

Chairman BLILEY. Yes, the gentleman from Ohio.

Mr. STRICKLAND. I have a question for Mr. Inlander. You say in your testimony that the most important point to remember about the information contained in the Data Bank is that it does not include charges made against a practitioner.

Mr. INLANDER. Right.

Mr. STRICKLAND. Rather, the Data Bank contains only actions taken against a doctor by a recognized entity—a State licensing board, a court, hospital or a Federal agency.

But let me ask you this question. If an insurance company settles a suit on behalf of a doctor and that doctor is not allowed to contest the claim, isn't that really akin to a charge, as opposed to an actual guilty verdict? In other words, in your view are malpractice claims the same as guilty verdicts? Would—

Mr. INLANDER. You mean settlements, malpractices, not claims settlements?

Mr. STRICKLAND. Yes.

Mr. INLANDER. I am not suggesting it is guilt. I have never said that these guilty—any of these things constitute guilt. But they are actions. They are actions—they are actions that were filed with the court as a settlement, not in the name of the malpractice insurance company of Ohio but in the name of the doctor. So I can't deal with and worry about, frankly, as a consumer whether the law allows these kinds of things to go on, where an insurance company can settle basically by shoving it down the doctor's throats. That is not our issue here.

The issue is that the information that the doctor did settle the case—and that is all it means, and I think it is important to understand that as a consumer that doesn't mean I won't go—and I don't think the persons who spoke on the first panel meant that—necessarily meant I wouldn't go to that doctor but would you explain what this was. If Dr. Corlin was—told me what happened in the case that was his case, I wouldn't have said to myself, I won't use him. I would have only said, don't use that Japanese instrument on me.

I think that is the issue here and think the only way we are going to even know ask the question is if we have that information.

Mr. PLUNKETT. Mr. Chairman, I have a little information about—this is something that hasn't come up.

Chairman BLILEY. Thank you.

Mr. PLUNKETT. I think we have created a false impression here that somehow malpractice settlements are occurring willy nilly in large numbers. Let's be truthful here. When a consumer group in New York was able to get their hands on and do a study of the anonymous physician data base for physicians in New York, what they found was, looking at the National Practitioner Data Bank, only 5 percent of all physicians in the entire State of New York had more than one malpractice settlement. So we are talking at this point about a very small number of physicians.

And what settlements can tell you, it can talk to you about the outlaw physicians, the physicians who, very few in number, are causing a lot of grief for a lot of families.

The New York Daily News also was able to look at some information on the National Practitioner Data Bank. They cross-referenced it to court records and they found that the eight top physicians in the entire State of New York had 92 settlements or judgments. What was occurring was that you saw a number of settlements—bing, bing, bing—with some of these physicians, then a judgment and a number of settlements, then a judgment. So, in the extreme, these settlements do tell you something. They are very small—the number of physicians who are affected are very small in number, and the public has a right to know about these people.

Mr. STRICKLAND. But what is it they tell you is the question.

Chairman BLILEY. The time of the gentleman has expired.

Mr. GANSKE. Mr. Chairman, I ask unanimous consent for 1 minute to follow up some data on Mr. Plunkett's assertion.

Chairman BLILEY. The gentleman is recognized for 1 minute.

Mr. GANSKE. Thank you, Mr. Chairman. Because I have data here on neurosurgeons from 1994 and 1993 and 1992, and 1991. Each year there was close to about—each year there was approximately 1,200 respondents and each year there were around 200 claims. So the problem is the cumulative effect. Over a 15- or 20-year practice period, a neurosurgeon very well could add up to a fair number of settlements.

That is one of those high-risk specialties, the guys that take on the ruptured aneurysm and end up with patients that may not do so well. So I think that is part of the problem. It isn't just in any given year. It is the cumulative effect over a lifetime of practice that needs to be taken into consideration on the settlement issue.

Thank you.

Chairman BLILEY. I thank the gentleman.

I thank the panel. I think you have been very helpful to the committee. The committee may have some additional questions that we would submit to you in writing, and I hope you would respond to them. Thank you.

Mr. GANSKE. Mr. Chairman, if I might add something to my testimony. That is that when I was talking about some type of national data information, I didn't necessarily mean that this would be something done by the Federal Government. But I think it would be very useful to build on something, for instance, like the Federation of State Medical Boards. It would be useful to have them testify some time.

Chairman BLILEY. Thank you.

We will now hear from the third panel, first witness in the third panel; and I apologize again to all of you for having to wait so long.

The first witness is Ms. Nancy Achin Sullivan, Executive Director, Board of Registration and Medicine, Commonwealth of Massachusetts. Ms. Sullivan.

STATEMENTS OF NANCY ACHIN SULLIVAN, EXECUTIVE DIRECTOR, BOARD OF REGISTRATION IN MEDICINE, COMMONWEALTH OF MASSACHUSETTS; CLAUDE EARL FOX, ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY THOMAS CROFT, DIRECTOR, DIVISION OF QUALITY ASSURANCE, BUREAU OF HEALTH PROFESSIONS; GLORIA CRAWFORD HENDERSON, DIRECTOR, DIVISION OF MEDICAL QUALITY ASSURANCE, FLORIDA DEPARTMENT OF HEALTH; PATRICK J. CLEARY, VICE PRESIDENT FOR HUMAN RESOURCE POLICY, NATIONAL ASSOCIATION OF MANUFACTURERS; DONALD J. SENESE, DIRECTOR OF RESEARCH, 60 PLUS; AND KERRY HICKS, CHIEF EXECUTIVE OFFICER, HEALTHGRADES.COM

Ms. SULLIVAN. Thank you, Mr. Chairman.

As you said, I am Nancy Achin Sullivan from the Massachusetts Board of Medicine; and I am here to try to outline the experience of Massachusetts in the development of the first-in-the-Nation physician profiles program.

Almost exactly 4 years ago, we in Massachusetts were really in the same place that I think this committee, perhaps this Congress finds itself today. We were about to embark and release to the public an unprecedented amount of information about our physicians, including comprehensive business demographics on each doctor, as well as information on hospital and board discipline, criminal convictions and paid malpractice.

In the beginning, we, too, were beset with huge estimates of the probable cost in both time and money which would be required to produce a worthwhile product. In fact, it took us only 8 months and a fraction of the original cost estimates to implement the first profiles program. The implementation of this program is neither technically complicated nor prohibitively expensive. In Massachusetts, the entire implementation was completed by three staff members, only one of whom worked exclusively on profiles. The implementa-

tion costs were approximately \$300,000 on a doctor population of approximately 25,000.

Certainly the per physician cost associated with similar programs should be even lower since so much of the work pioneered by Massachusetts can be replicated by subsequent programs.

At the end of the effort, our data files were the most accurate in the board's 106-year history; and we had in place a system which would produce 30,000 updated physician profiles every single day, with multiple points of access for consumers seeking information.

Just as this committee has listened with great care and attention to the witnesses with interest in this bill, we listened to the very valid concerns of our physicians, our health care organizations and our general citizens about the publication of the information.

We designed our program to benefit individual consumers. We captured information with the greatest interest to our consumers—insurance plan coverage, hospital affiliation, and area of medical specialty.

We crafted appropriate controls to prevent the data from being used to target physicians with frivolous lawsuits, and we included an appeals process by which the individual physician could correct or amend information. We worked very hard to strike the proper balance between being helpful to the citizens and fair to the doctors.

Physician profiling has been unqualified success in Massachusetts. It is an accepted and even essential part of the health care environment in our State. None of the predictions of doom and gloom came true, and the citizens have benefited greatly.

I can tell you from personal experience there is no more compelling force in government for excellence than a requirement to publish the results for public consumption. Our public service performance has improved tremendously as a result of our responsibility to publish physician profiles. Our data quality is better, our staff is sharper, and our closeness in partnership with the public and its concerns have never been more intimate or important to us.

Having been down this road with the most experience, we are enthusiastic supporters of the public information goals of H.R. 5122. We believe it incorporates all of the most important lessons learned about profiling physicians—full disclosure of relevant information, contextual presentations to assist consumers in making truly informed choices—it is not raw data—excellent accessibility using advanced user-friendly information technology.

We believe it could improve the work of State agencies by giving us unfettered access to the hundreds of thousands of physician records otherwise unavailable. A disclosure program such as that outlined in H.R. 5122 would supplement, not supplant, our initiatives. We would continue to maintain aspects of the Massachusetts's physician profiles that are important to our program and to our citizens, such as honors and awards and published research of our physicians; and we would tie those enhancements into the data supplied through the national data system.

In Massachusetts, for example, we would use a national program to provide us more complete information about the 10,771 Massachusetts physicians who hold licenses in other States as well. Currently, we are banned from disclosing any information about the

nonMassachusetts practice of these physicians, who represent 37 percent of our physician population, because our source for the information would be the Data Bank.

Physician profiling is an initiative whose time has come. Far from being a radical or unproved step into unknown territory, it is a reasonable and timely initiative, carefully crafted, built on 4 years of solid experience in Massachusetts and incorporates everything we know about the publication of relevant, usefully formatted health care information for the benefit of the public. It empowers consumers and places a burden of excellence on government agencies. It makes government better, it makes us more accessible and more accountable, and it demonstrates our fundamental belief in the ability of our fellow citizens to make good choices and good judgments about their own health care.

By even discussing changes to the NPDB, this committee is raising the level of public debate. Chairman Bliley, as a patient rights activist, I salute you for that courage.

Through both compromise and courage this Congress can bring fundamental improvement to the quality of health care in this country. And I speak not only as a health care regulator but as a person with cancer who has fought very hard to be well enough to come here today. You can all decide to keep people like me safer or stronger and healthier or you can decide to fall into partisan politics and other issues and not do that.

I thank you for the opportunity to come and ask you to do the former.

[The prepared statement of Nancy Achin Sullivan follows:]

PREPARED STATEMENT OF NANCY ACHIN SULLIVAN, EXECUTIVE DIRECTOR,
MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE

My name is Nancy Achin Sullivan. I am Executive Director of the Massachusetts Board of Registration in Medicine. I am here to offer assistance to the House Committee on Commerce in its consideration of H.R. 5122, the Patient Protection Act, by outlining the experience of Massachusetts in the development of its Physician Profiles program.

Almost exactly four years ago, we in Massachusetts were facing circumstances similar to those in which the members of this Committee find themselves today. We were, for the first time ever in this country, about to release to the public an unprecedented amount of information about our physicians. This information included a comprehensive set of business demographics on each doctor, as well as other information, including hospital and board discipline, criminal convictions, and paid malpractice claims.

In the beginning we, too, were beset with huge estimates of the probable cost in time and money that would be required to produce a worthwhile product. In fact it took us only eight months and a fraction of the original cost estimates to implement the first profiles program. The implementation of this program is neither technically complicated nor prohibitively expensive. In Massachusetts, the entire implementation was completed by three staff members, only one of whom worked exclusively on Profiles. The implementation costs were approximately \$300,000. Certainly the per physician cost associated with similar programs should be even lower since so much of the work pioneered by Massachusetts can be replicated by subsequent programs.

At the end of the effort, our data files were the most accurate in the board's 106-year history, and we had in place a system which would produce 30,000 updated physician profiles every single day, with multiple points of access for consumers seeking the information.

Just as this Committee has listened with great care and attention to the witnesses with an interest in H.R. 5122, we at the Massachusetts Medical Board had listened with equal care and attention to the valid concerns of our physicians, our health care organizations, and our citizens about the publication of this information.

We designed our program to benefit individual consumers and captured the information of greatest interest to our consumers—insurance plan coverage, hospital affiliation, and area of medical specialty.

We crafted appropriate controls to prevent the data from being used to target physicians with frivolous lawsuits, and we included an appeals process by which the individual physician could correct or amend information. We had worked hard to strike the proper balance between what would be helpful to our citizens and what would be fair to our doctors.

Physician profiling has been an unqualified success in Massachusetts. Today it is an accepted, even an essential, part of the health care environment in Massachusetts. None of the apocalyptic predictions came true, and the benefits to our citizens, and to the quality of our public service mission, have been great.

I can tell you from personal experience, there is no more compelling force for excellence in government than a requirement to publish results for public consumption. Our public service performance has improved by an order of magnitude as a result of our responsibility to publish physician profiles. Our data quality is better, our staff is sharper, and our closeness to the public and its concerns has never been more intimate.

Having been down this road, we are enthusiastic supporters of the public information goals of H.R. 5122. We believe it incorporates all of the most important lessons learned about profiling physicians: full disclosure of relevant information, contextual presentations to assist consumers in making truly informed choices, and excellent accessibility using advanced user-friendly information technology.

We believe that it could improve the work of state agencies by giving us unfettered access to hundreds of thousands of physician records otherwise unobtainable. A disclosure program such as that outlined in H.R. 5122 would supplement, not supplant, local initiatives. We would continue to maintain the aspects of Massachusetts Physician Profiles that are important to our program, such as honors and awards and published research, and tie those enhancements into the data supplied through the national data system.

In Massachusetts, we would use a national program to provide more complete information about the 10,771 Massachusetts physicians who hold licenses in other states, as well. Currently, we are banned from disclosing any information about the non-Massachusetts practice of these physicians, who represent 37% of our total physician population.

Physician profiling is an initiative whose time has come. Far from being a radical or unproved step into unknown territory, it is a reasonable and timely initiative, carefully crafted, built on four years of solid experience, which incorporates everything we know about the publication of relevant, usefully-formatted health care information for the benefit of the public. It empowers consumers and places a burden of excellence upon the government agencies responsible for its implementation. It makes government better, more accessible, and more accountable, and it demonstrates our fundamental belief in the ability of our fellow citizens to make good choices and good judgements about their own health care.

By even discussing changes to the NPDB, this Committee is raising the level of public debate. As a patient rights activist, I salute Chairman Bliley and all the Committee members for your leadership. Through both compromise and courage, this Congress can bring fundamental improvement to the quality of health care in this country.

I speak not only as a health care regulator, but as a person with cancer who has fought very hard to be well enough to come here today. You can decide to keep people like me safer and stronger and healthier. Thank you for the opportunity to ask you to do just that.

Chairman BLILEY. Thank you.

Mr. Croft. Mr. Thomas Croft, Director of Division of Quality Assurance, Bureau of Health Professions, at the Department of Health and Human Services. Mr. Croft.

STATEMENT OF THOMAS CROFT

Mr. CROFT. Thank you, Mr. Chairman. I appreciate the opportunity to be here to represent the administration on this important bill.

We recognize that the central issue here before the committee indeed involves public disclosure of information in the National Prac-

itioner Data Bank. I am going to skip over some of my testimony because it contains reflections that have already been made by others here today. I only want to mention that, first of all, that the Secretary has written you on this subject; and I believe that what she said to you and what we mentioned in earlier testimony still is the position of the administration on this important subject.

I was struck by the fact that nearly every single specific case that was been mentioned today has to do with practitioners who seem to have multiple problems. What I don't think has been emphasized is that the vast majority of practitioners who have a record in the National Practitioner Data Bank only have one report and that almost always is a malpractice report, and I only mention that to underscore some of the concerns that have already been mentioned.

Having said that, we certainly are interested in working with you on any legislative provision that would improve the Data Bank. We welcome provisions that would improve its current operation and enhance its current mission, such as closing reporting loopholes, improving compliance and data collection and applying Data Bank requirements uniformly to the entire U.S. health care system, including Federal agencies.

We remain extremely concerned that well over half of U.S. hospitals have never reported a single adverse clinical privileges action to the Data Bank. Underreporting is aided by the lack of civil penalty for failure to report.

Mr. Chairman, to modify the National Practitioner Data Bank to allow for public disclosure would be a major undertaking and would, therefore, take time. The likely timeframe to bring such a system into operation we believe would be 2 to 3 years, depending on the methods chosen for public disclosure. The regulatory process, including the opportunity for public comment, along with carefully planned program and implemented modifications to the NPDB's Internet-based system, would be time-consuming as well as costly.

I would note, however, that this legislative proposal would eliminate the Data Bank's authority to collect fees for providing information. We would not recommend such a change. As you know, the Data Bank, unlike the vast majority of Federal programs, is not funded by taxpayer dollars. In an environment where the Federal Government is being encouraged to model itself more like the private sector, the NPDB is ahead of the curve. Funded entirely by user fees, the NPDB functions more like private sector businesses, which has led us to employ the kind of business practices which continuously improve service to our customers. Moreover, the fact that nearly 70 percent of the Data Bank's revenue comes from voluntary requests for information suggests that health plans and other health care recipients believe they are receiving fair value for their payments.

The NPDB must currently cover its cost through fee collection and has done so successfully for 10 years through fee collection. The NPDB provides information within hours to queries, using the latest technologies which maximize speed, convenience and security while minimizing financial burden to its customers and not imposing any burden on U.S. tax papers.

In conclusion, Mr. Chairman, we remain committed to working with you to find ways to make the services of the Data Bank more responsive to the public's needs. This concludes my remarks.

[The prepared statement of Thomas Croft follows:]

PREPARED STATEMENT OF THOMAS CROFT, DIRECTOR, DIVISION OF QUALITY ASSURANCE, BUREAU OF HEALTH PROFESSIONS, HEALTH RESOURCES AND SERVICES ADMINISTRATION

Mr. Chairman, I am Thomas Croft, Director of the Division of Quality Assurance in the Bureau of Health Professions, Health Resources and Services Administration. The Division oversees the operation of the National Practitioner Data Bank. I appreciate the opportunity to address the Committee today about the Data Bank and the important issues raised in this bill.

As you know, the National Practitioner Data Bank was created in response to the requirements of the Health Care Quality Improvement Act of 1986 and plays a vital role in the important process of practitioner credentialing. It provides verification of sensitive adverse information about practitioners in an efficient and reliable manner, while, at the same time, maintaining the security and confidentiality required by law. The Data Bank also captures information on malpractice payments and settlements.

The central issue before the Committee today concerns public disclosure of Data Bank information. In an earlier response to Chairman Bliley on this subject, the Secretary wrote: "The issue of disclosing to the public information contained in the NPDB is complex. On one hand, I agree with your assertion that consumers need more information in order to make educated decisions regarding the medical professionals whose treatment they may wish to seek. On the other hand...there are privacy concerns regarding broad public disclosure of potentially incomplete negative information." While considering expanded public access to the Data Bank, significant privacy and data verification have been identified which need to be carefully considered.

We also should be mindful that, when malpractice claims are settled, findings about the standard of care, or about liability, are rarely made. Any proposal to make information public would need to provide either for a mechanism by which such determinations could be made; or some indication that the practitioner may not have done anything wrong.

Congressional intent seemed quiet clear in the Health Care Quality Improvement Act that established the Data Bank: that the Data Bank's information is not specifically intended to produce an independent determination about the competency of an individual practitioner. Rather, that information is intended to supplement a comprehensive and careful professional peer review. As such, the Data Bank information is incomplete for the purpose of disclosure to the public to use as the source of information on which to base a decision on whether to use a specific provider.

The vast majority of practitioners who have reports listed in the Data Bank have only one report; and in those instances it is almost always a malpractice payment report. As previous testimony before the Committee has emphasized, it is impossible and unfair to conclude from a single malpractice payment report alone, or even in some cases from numerous malpractice payment reports, anything substantive about the competence of a practitioner. To do so would be a disservice to all parties involved. At the same time, it is easy to understand the public's frustration with the lack of entirely accurate and unbiased information, particularly when some licensing authorities are slow to act in the face of practitioners' histories of poor or shoddy medical practices.

We certainly are interested in working with you on any legislative provision that improves the Data Bank. We welcome provisions that would improve its current operation and enhances its current mission, such as closing reporting loopholes, improving compliance and data collection, and applying Data Bank requirements uniformly to the entire U.S. health care system, including federal agencies. We remain extremely concerned that well over half of U.S. hospitals have never reported a single adverse clinical privileges action to the Data Bank. Under-reporting is aided by the lack of civil penalty for failure to report.

Mr. Chairman, to modify the current NPDB to address concerns and allow for public disclosure would be a major undertaking—and would therefore take time. A likely time frame to bring such a system into operation would be two to three years, depending on the methods chosen for public disclosure. The regulatory process, including the opportunity for public comment, along with carefully planned, pro-

grammed and implemented modifications to the NPDB's Internet-based system, would be time-consuming as well as costly.

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As you know, the Data Bank, unlike the vast majority of federal programs, is not funded by taxpayer dollars. In an environment where the federal government is being encouraged to model itself more like the private sector, the NPDB is ahead of the curve. Funded entirely by user fees, the NPDB functions more like private sector businesses, which has led us to employ the kind of business practices which continuously improve service to our customers. Moreover, the fact that nearly seventy percent of the Data Bank's revenue comes from voluntary requests for information suggests that health plans and other health care entities believe they are receiving fair value for their payments.

The NPDB currently must cover its costs through fee collection and has done so successfully for ten years. Through fee collection, the NPDB provides information within hours to queriers using the latest technologies, which maximize speed, convenience, and security, while minimizing financial burden to its customers, and not imposing any undue burden on the U.S. taxpayers.

In conclusion, Mr. Chairman, we remain committed to working with you to find ways to make the services of the National Practitioner Data Bank more responsive to the public's needs. Mr. Chairman, this concludes my remarks. I am happy to address your questions.

Chairman BLILEY. Thank you, Mr. Croft.

Ms. Gloria Crawford Henderson, Director of the Division of Medical Quality Assurance of the Florida Department of Health will be next. Ms. Henderson, the floor is yours.

STATEMENT OF GLORIA CRAWFORD HENDERSON

Ms. HENDERSON. Thank you, Mr. Chairman. I have been asked to speak with you regarding Florida's experience with implementing a practitioner profiling system.

In Florida, practitioner profiles are currently available via the Internet on allopathic, osteopathic, chiropractic and podiatric physicians. These profiles include certain biographical, educational and professional information as well as criminal, disciplinary and medical malpractice histories, if they exist.

In my written testimony I outline for you the specific data elements included in the practitioner profiles, but some of those examples are medical education, address of primary practice site, hospitals at which practice privileges have been granted, specialty board certification, medical school faculty appointments, criminal offenses, final disciplinary action taken within the past 10 years and, through a link to the Florida Department of Insurance, medical malpractice settlement information.

Physicians are also allowed to include such information in their profiles as publications in peer-reviewed medical journals, professional or community service activities or awards, evidence of their ability to communicate with patients who have limited English skills, and whether they participate in the Medicaid program.

Physicians are required to update their profiles within 45 days of a change. Failure to do so could result in disciplinary action.

Because Florida's practitioner profiles do not give the consumer a comprehensive record of the physician's practice history, our Web site contains a very important disclosure notice. In this disclosure notice, we share with the consumer the limitations of our system. For example, ours is a self-reported system and some of the data elements have not been primary source verified. Also, disciplinary

actions and liability claims that occurred more than 10 years ago are not included in the profiles, and disciplinary actions taken by a hospital or an ambulatory surgery center are also not included in the profiles.

Legislative deliberations concerning the advantages and disadvantages of this consumer protection issue focused on a number of key concerns, many of which we have discussed in detail today, so I won't go into those in the interest of time. But at the heart of the debate in Florida when the issue was before us was, do patients have a fundamental right to more information about their physicians that is, one, readily available and, two, easy to understand.

As you can imagine, key stakeholders weighed in on all sides of this issue. In the end, the 1997 Florida legislature decided that consumers would be in a better position to make wise choices when selecting physicians if they had some objective data upon which to base their decisions. Profiles have been available on Florida-licensed physicians since July 1999. An analysis of the available data indicates that our Web site is being accessed on average more than 15,000 times per month.

As a closing remark, I would add we realize that improving the overall quality of health care is a very complex and multidimensional issue, and focusing on individual practitioner performance will not fix our systemic problems. However, in Florida, we look at medical excellence as a work in progress and we consider practitioner profiles being available to consumers an extremely important first step.

At the same time that we are giving the consumer more information we are also taking a detailed look at all the various components of the health care delivery system through a legislatively created Commission on Excellence in Health Care. This is a 42-member think tank that is charged with looking from a system-wide perspective at ways to improve upon our existing patient protection initiatives. The Commission is required to give a legislative report by February 1, 2001.

Because knowledge is power, we believe that giving consumers more information will empower them to become valuable partners with us in our quest toward medical excellence. After all, nobody has more of a vested interest in seeing that the system improves than the health care consumer.

Thank you.

[The prepared statement of Gloria Crawford Henderson follows:]

PREPARED STATEMENT OF GLORIA CRAWFORD HENDERSON, FLORIDA DEPARTMENT OF HEALTH, PRACTITIONER REGULATION PROGRAM.

Thank you, Chairman Bliley and committee members, for giving me an opportune to speak to you about Florida's experience with practitioner profiling. My name is Gloria Crawford Henderson, and I manage the Florida Department of Health's practitioner regulation program.

In Florida, practitioner profiles are currently available to the public on the World Wide Web site on allopathic, osteopathic, podiatric, and chiropractic physicians. Effective July 1, 2001 profiles will also be available on advanced registered nurse practitioners. Since these profiles are not currently available, my comments will, for the most part, be limited to licensed physicians.

Florida's initial legislative effort to give consumers easy access to certain already public information on physicians was a bipartisan, consumer-driven partnership between two senior legislators who were committed to the principle that knowledge

is power and an informed consumer is an empowered consumer. After numerous committee hearings where an extensive amount of testimony was considered, a legislative mandate directing the Florida Department of Health to develop and publish practitioner profiles on physicians passed by an overwhelming margin.

Since July 1, 1999 the following information has been available to consumers, via the Internet, on allopathic, osteopathic, podiatric, and chiropractic physicians:

- The name of each medical school that the physician has attended, including the dates of attendance and the date of graduation, and a description of all graduate medical education completed, excluding any coursework taken to satisfy medical licensure continuing education requirements.
- The name of each hospital at which the physician has privileges.
- The address at which the physician will primarily conduct his/her practice.
- Any certification that the physician has received from a specialty board that is recognized by the applicable regulatory board.
- The year the physician began practicing medicine.
- Any appointment to the faculty of a medical school which the physician currently holds and an indication as to whether the physician has had the responsibility for graduate medical education within the most recent ten years.
- A description of any criminal offense of which the physician has been found guilty, regardless of whether adjudication of guilt was withheld, or to which the physician has pled guilty or nolo contendere. A criminal offense committed in another jurisdiction, which would have been a felony or misdemeanor if committed in this state must be reported. If the physician indicates that a criminal offense is under appeal and submits a copy of the notice for appeal of that criminal offense, the Department of Health is required to state (on the profile) that the criminal offense is under appeal if the criminal offense is reported in the physician's profile. If the physician indicates to the department that a criminal offense is under appeal, the physician must, upon disposition of the appeal, submit to the department a copy of the final written order of disposition.
- A description of any final disciplinary action taken within the previous ten years against the physician by the agency regulating the profession that the physician is or has been licensed to practice, whether in Florida or in any other jurisdiction, by a specialty board that is recognized by the American Board of Medical Specialties, the American Osteopathic Association, or a similar national organization, or by a licensed hospital, health maintenance organization, prepaid health clinic, ambulatory surgical center, or nursing home. Disciplinary action includes resignation from or nonrenewal of medical staff membership or the restriction of privileges at a licensed hospital, health maintenance organization, prepaid health clinic, ambulatory surgical center, or nursing home taken in lieu of or in settlement of a pending disciplinary case related to competence or character. If the physician indicates that the disciplinary action is under appeal and submits a copy of the document initiating an appeal of the disciplinary action, the department must state that the disciplinary action is under appeal if the disciplinary action is reported in the physician's profile.

Effective July 1, 2001 this information, as applicable, will also be available on advanced registered nurse practitioners.

Key information not available to the public in practitioner profiles includes:

- Disciplinary action and liability claims that occurred more than 10 years ago.
- Disciplinary actions taken by a hospital or ambulatory surgery center.
- Federal criminal history information.

Practitioner profiles summarize data submitted by allopathic, osteopathic, podiatric, and chiropractic physicians; some of which has not been verified. Additionally, as indicated above, practitioner profiles do not give the consumer a comprehensive record of the physician's practice history. As a result, the practitioner profile Web site contains a disclaimer notice that serves as a contextual device for consumers.

Consumers can obtain civil medical malpractice payment information from the county in which the physician practices. Consumers can also link to the Florida Department of Insurance's Web site for other medical malpractice payment information.

Deliberations concerning the merits and demerits of this extremely important consumer empowerment and protection issue were extensive, and focused on the following key elements:

- Balancing professional reputations of physicians with the public's right to know
- What information, that is not already readily available, does the consumer need to make informed choices?
- What are the true indicators of a physician's competence?

- Because physicians who handle the toughest cases are likely to have more malpractice suits, will making this information readily available to the public unfairly adversely affect them?
- Will making this information readily available to the public reduce the number of physicians who engage in cutting edge clinical practice or go into high risk fields of medicine?
- Does the focus on profiles place too much emphasis on individual practitioners rather than the myriad of systemic challenges we face?
- How can we ensure the information is relevant, accurate and in the proper context?
- Is this initiative necessary in view of the fact that there are discussions at the national level to open up nationwide data bases to the public?
- How do we protect the due process rights of physicians?
- Will patient access be adversely affected because physicians decide not to practice in Florida?
- Do medical malpractice claims and settlements accurately depict physician competence?

At the heart of the discussion was the issue of whether patients have a fundamental right to more information about their physicians that is readily available and easy to decipher. As you can imagine, this was a highly contentious issue, with key stakeholders weighing in on both sides. In the end, the 1997 Legislature decided that, with certain caveats, it was in the best interest of the public for Florida to offer its consumers easy access to certain educational, professional, disciplinary, and malpractice information on physicians.

Despite rampant fears, an analysis of available data indicates the following:

- Since its inception on July 1, 1999 Florida's practitioner profile Web site has been accessed approximately 200,000 times, averaging more than 15,000 hits per month.
- The total number of licensed physicians continues to increase, so it does not appear that practitioner profiling legislation has adversely affected patient access.
- Although physicians were initially very concerned about the possible adverse ramifications of publication of profiles, actual experience has significantly reduced their apprehensions.
- Consumers are demanding more, not less, information about health care practitioners.

In response to the public outcry for more information about health care practitioners, the 2000 Florida Legislature considered the merits of profiling all regulated health care practitioners. Although the proposal was defeated, it was deliberated and did receive bipartisan support. This suggests that there may be future discussions in Florida related to making practitioners' records readily available to the public.

In conclusion, improving the overall quality of health care is a complex challenge that requires a detailed evaluation of all the various components of the delivery systems. There is no single answer to this complicated goal, however, empowering consumers to assist with this mammoth undertaking by giving them the tools they need to make wise choices appears to be a step in the right direction. While we do not see this as the only quality improvement option, it has certainly been a very important first step.

Chairman BLILEY. Thank you.

Next we will hear from Mr. Patrick Cleary, Vice President for Human Resource Policy, National Association of Manufacturers.

STATEMENT OF PATRICK J. CLEARY

Mr. CLEARY. Thank you, Mr. Chairman. Thank you, too, for holding this hearing today and for focusing on this issue and sponsoring this legislation. It is critically important to your society, and we appreciate your leadership not just for the past 20 years, but especially on this issue. So we thank you.

First and foremost, I will summarize my remarks. We have supplied them to you separately.

The NAM is 14,000 manufacturers in the country and every State in this country and every congressional district. Of those 14,000, 10,000 employ 500 or fewer employees, so a fair amount of

our members are fairly small employers, a fact not often known. Together, they employ 18 million people in America.

And we make things. We make golf balls and whiskey and steel and cars and all sorts of good things.

Chairman BLILEY. You didn't bring a sample, did you?

Mr. CLEARY. We didn't bring any samples. We will submit those separately to the committee.

We make everything in this country, and all our members—virtually all our members supply health care to their employees, provide health care to their employees and their dependents. Together, the employer-based system—not just the manufacturers, but all employers cover 120 million people in this country. In other words, the doctors do the treatment, but we pay the bills.

Over 60 percent of the insured marketplace is insured through the employer-based system, and by the way, I should mention, that is a voluntary system. Employers do it because they want to, not because they are required to.

We support, obviously, the Patient Protection Act, H.R. 5122. It is consistent with our long-standing efforts, employers-at-large and the NAM specifically, to improve health care quality by providing health care purchasers and consumers with better information.

We salute the doctors, the doctors in this room and those who testified. We have the best doctors in the world right here in America, but every now and then a few of them jump the track. There are a few bad apples out there. They are not perfect and there are errors.

According to the 1999 Institute of Medicine study which we have heard a lot about today, more people die from medical errors than from AIDS or motor vehicle accidents or breast cancer; and all of those three have received a pretty fair amount of popular media coverage. But by the ION study, their estimate is between 44,000 and 98,000 deaths per year from medical errors. To put that in context, that is somewhere between the population of Rockville, Maryland, and Portsmouth, Virginia, to give you some idea. That is a lot of people.

The issue is rising in public consciousness. I was getting ready for these hearings the other night, and I am watching TV. There was a 30-second spot for a new TV show coming on called "Gideon's Crossing," a medical show coming on ABC this fall; and there was a little blurb there where they talked about doctors' errors and how many people it kills every year. So clearly it is working its way into the public lexicon and it will fundamentally impact the public's trust in the profession; and so clearly the profession needs to be concerned about this and moving to take some steps.

Clearly, as we see it, there are a couple of trends. There is technology which is making this so much easier to keep track of and to make available to the public. And we are a transient society. In the old days, in a small town like where I grew up in, if there was an error or if there was a bad doctor in town, everybody knew about it. But I moved from that town, and just about everybody moved from that town. Our biggest export was people. And so you don't have that any more.

So if you have a State-by-State system, that is great but people move from State to State to State. Dr. Ganske, who is now here

in Washington, how does he begin to pick a good physician? You don't have that same infrastructure that we used to have in 1920's America.

In technology, obviously there have been those same sorts of changes. We ought not be like Luddites, where we break the machines and blame the machines that are threatening us. We need to embrace that change.

I went on the Internet last night to surf a little bit, and you look at the National Highway Traffic Safety Administration Web site. There is information on all the recalls there. The Occupational Safety and Health Administration has information on every one of our employers who has been cited or inspected since 1972, very detailed information. Certainly the Consumer Products Safety Commission.

You can find sex offenders, health code violations; and no less an expert than Alan Greenspan was quoted yesterday as saying that public disclosure will play a larger role in helping government regulators ensure the safety of the nation's banking system.

So we come down on the side of disclosure across the board.

I would conclude by saying, we think a practitioner's data base should be open to the public. I think I paraphrase Senator Wyden when I say there really is no logical argument for not opening this information up to the public. Certainly we are happy to work with the committees, the AMA and anyone else to clearly provide a contextual reference if that is needed, but certainly that information should be out there.

That concludes my remarks. I will be happy to take questions at the appropriate time.

[The prepared statement of Patrick J. Cleary follows:]

PREPARED STATEMENT OF PATRICK J. CLEARY, VICE PRESIDENT FOR HUMAN RESOURCES, NATIONAL ASSOCIATION OF MANUFACTURERS

Mr. Chairman, on behalf of the more than 14,000 members of the National Association of Manufacturers, I would like to commend you for introducing the Patient Protection Act of 2000. The NAM strongly supports your bill to provide consumers access to detailed information on their physicians. We commend you for working to lift the public veil on the National Practitioner Data Bank.

The National Association of Manufacturers—18 million people who make things in America—is the nation's largest and oldest multi-industry trade association. The NAM represents 14,000 member companies (including more than 10,000 small and mid-sized manufacturers) and 350 member associations serving manufacturers and employees in every industrial sector and all 50 states. Headquartered in Washington, D.C., the NAM has 10 additional offices across the country.

Improving Health Care Quality

NAM members are strongly committed to providing health care benefits to their workers and their workers' dependents. Indeed, 98 percent of NAM members provide health benefits to their workers and dependents. Our members have always worked to ensure that workers and manufacturers receive the best quality care for their health care dollar. Employers have helped drive the quality revolution through such entities as the National Center for Quality Assurance, URAC / The American Accreditation HealthCare Commission and the Foundation for Accountability (FACCT). More and better information will continue to help the health care purchaser—whether business or individual—make better choices among diverse health coverage options.

Health care purchasers and consumers are at a greater disadvantage when it comes to selecting individual physicians. While health insurance networks—much maligned in the current managed care debate—can provide some reassurance of reasonable physician competence to the health care consumer, we are left by and large

with word-of-mouth advice from family, friends or peers if we are lucky...or from a thick provider book or the yellow pages if we are not.

The chairman's bill seeks to give consumers a powerful tool with which to evaluate individual physicians by providing access to the National Practitioner Data Bank, a taxpayer-funded entity. The committee has prepared an excellent mockup of what this database might look like on the web. Consumers will be able to scroll down through information on medical malpractice payments, criminal convictions, hospital discipline, board discipline and Medicare/Medicaid exclusions. I know I would want to know what is in a doctor's database before he or she treated a family member or me. Wouldn't we all?

Protecting Against the Few Dangerous or Incompetent Physicians

American physicians are among the finest in the world. The evidence of the high quality of our health care system can be seen in the numbers of our northern neighbors who come south for treatment or our southern neighbors who come north. We are justly proud of the professional medical men and women in whom we place our lives and trust.

This legislation seeks to address the exceptions to that high professionalism, the aberrations that shake the public trust in the medical profession. Examples abound of physicians who have managed to skip ahead of disciplinary proceedings and others who have been left behind by changes in the practice of medicine or the erosion over time of their skills. The example cited in a previous hearing of the New York physician who carved his initials in a woman's abdomen defies comprehension.

The estimate in the Institute of Medicine's report "Building a Safer Health Care System: To Err Is Human" dramatizes our problem: 44,000—98,000 people die each year as consequence of medical errors. While not all of these are a result of physician errors, we should be united in our desire to protect the public and eliminate these errors to the greatest extent possible. Senator Wyden's comment in the March hearing is right on point:

"...there is no logical argument for keeping information about proven flagrant cases of public misconduct from the public. For the federal government not to disclose this important information in the Data Bank about physician misconduct simply doesn't pass the smell test." [Statement of Sen. Ron Wyden, House Commerce Subcommittee on Oversight and Investigations, March 1, 2000.]

Present measures to deter medical errors—medical malpractice lawsuits and disciplinary proceedings by state boards of licensure—have proven ineffective, as the IOM study demonstrates. Despite widespread exposure to medical malpractice litigation, medical errors continue to occur and, given human nature, will probably always occur. The NAM and other members of the business community have long understood and sympathized with the medical community's fears on medical malpractice litigation. We find it fairly ironic that they have so misunderstood employers' unwillingness to submit to a very similar liability exposure under the Dingell-Norwood bill.

The Subcommittee on Oversight and Investigations' March hearing made clear that the ability of state boards of licensure to police physicians' competence varies widely. We encourage more states to take affirmative steps to fully fund their state board of licensure. In addition, the National Practitioner Data Bank was established to assist these state boards with better information on physicians' background and, particularly, information on physicians who move from state to state. We agree with the chairman that it can now do more.

The chairman's bill is not meant to supplant state boards of licensure or, for that matter, medical malpractice litigation. Health care consumers—which include all of us from time to time—deserve the chance to choose a physician with eyes open and with the benefit of the best information available. The chairman's bill is an appropriate and necessary step in this direction.

Is the Data Bank Ready?

The NAM would like to open up the Data Bank as soon as possible to protect consumers. We recognize, however, that many arguments as to its readiness were raised in the March subcommittee hearing and will no doubt be raised again today. Senator Wyden's testimony and expertise on this subject are persuasive as well.

A short pause before the Data Bank is opened to the public may make sense if it is used to get the Data Bank and the consumer interface to the Data Bank right. We fear that a longer delay might be used as an excuse to delay implementation indefinitely. Nevertheless, it is important that we not harm the vast majority of good physicians in the attempt to protect consumers from the few bad physicians.

A delay in implementing the Patient Protection Act for six months to no more than a year may be in order.

Conclusion

The NAM strongly supports the Patient Protection Act of 2000 and urges this Committee and the Congress to act swiftly to pass it before the 106th Congress adjourns sine die. I thank the Committee and will welcome your questions.

Chairman BLILEY. Thank you very much.

Mr. CLEARY. Next time we will bring samples.

Chairman BLILEY. Okay.

The next is Dr. Donald J. Senese—I hope I pronounced that correctly—the Director of Research of 60 Plus.

STATEMENT OF DONALD J. SENESE

Mr. SENESE. Thank you, Mr. Chairman. In the interest of time, let me just read a summary of my testimony.

The 60 Plus Association is a national senior citizens advocacy association of 500,000 members, roughly 1,000 per congressional district, and supported by voluntary donations of supporters. I bring greetings to you and the committee members from President Jim Martin and also Honorary Chairman Roger Zion, formerly a member of the House of Representatives.

60 Plus Association endorses the Patient Protection Act of 2000, legislation that would open the National Practitioners Data Bank to the public via the Internet. Congress created the Data Bank in 1986 and should open it to the taxpayer whose taxes fund it. This legislation would allow monitoring the occurrence of malpractice litigation and address the problem of physicians who lose their licenses or face discipline in one State and then move to another to practice medicine.

We believe that consumers should be entitled to this information as a matter of sound public policy, making medicine safer and empowering patients and consumers. In addition, this legislation also provides safeguards for doctors, protecting their privacy and their reputation.

The 60 Plus Association believes this legislation is especially needed for senior citizens to provide consumer information on doctors for present Medicare beneficiaries and for the baby boomers who will soon be Medicare recipients.

Thank you very much.

[The prepared statement of Donald J. Senese follows:]

PREPARED STATEMENT OF DONALD J. SENESE, DIRECTOR OF RESEARCH, 60 PLUS ASSOCIATION

Mr. Chairman and Members of the Commerce Committee, I am Dr. Donald J. Senese, Director of Research for the 60 Plus Association. I am pleased to be here today representing the 60 Plus Association testifying on The Patient Protection Act of 2000, which would open to the public the National Practitioners Data Bank allowing consumers to obtain the information they need to make informed decisions about their physicians.

I bring you greetings from our Honorary Chairman, the Honorable Roger Zion, a Member of the House of Representatives 1967-1975, and from our president Jim Martin.

The 60 Plus Association is a national, nonpartisan senior citizens' advocacy group with a membership of 500,000, about 1,000 per Congressional District.

In accord with The Truth in Testimony Requirement, the 60 Plus Association asserts that we have not received any federal grant or subgrant by a federal agency or a contract by a federal agency in the current year or preceding two years. We

exist by the voluntary donations of our thousands of supporters throughout the country, without seeking or accepting any federal aid or assistance.

We wish to commend the Chairman and members of this Committee for holding a hearing of such an important matter as we face today. This bill will be a major help to our senior citizens throughout the country.

The National Practitioners Data Bank contains valuable information regarding such crucial material as disciplinary and medical malpractice payment information about physicians. This Data Bank was established with federal tax dollars. Unfortunately, despite the fact that taxpayers have paid for it, currently it is not now available to the public.

The Patient Protection Act of 2000 provides a crucial benefit—access to information about those individuals who are treating them for medical reasons.

Consumers may be given a list of doctors and must choose without any background or information. This is one of the most critical decisions individuals will make as they will be entrusting this individual with their health and well being. The cost of a poor choice may mean poor treatment, inadequate attention to real medical needs, and unfortunately, consequences that may result in a more serious illness or even death. Our seniors, as well as others in our population, cannot take the risk from having no or inadequate information.

The vast majority of doctors, I am sure, are very qualified and dedicated to their profession.

However, we have closely followed your hearings. And we realize from the witnesses you have had—and the anecdotal stories we see in the press from time to time—that there are problems with doctors and it is crucial for potential patients to know these problems.

Congress created the National Practitioner Data Bank in 1986 to accomplish a number of objectives including providing better medical care and to monitor the occurrence of medical malpractice litigation. The Data Bank allows us to address the problem of physicians who lose their licenses or face discipline in one state by then moving to another state to practice medicine. Making this knowledge available to the public is sound public policy and will improve patient safety. We have the opportunity to make medicine safer and at the same time empower patients and consumers.

We also believe that this legislation provides proper safeguards for doctors, protecting both their privacy and their reputations.

We realize that there are certain drawbacks in the National Practitioner Data Bank, regarding the timely reporting of information and consumers understanding the type of information reported especially on different medical specialties. Despite these restraints, we have full confidence that we can depend on our citizens to make informed decisions based on the information available. And we are taking advantage of the advance in technology by making this information readily available over the Internet.

Though it may be an extreme case, the recent story of Dr. Michael J. Swango should send chills down our spines. He had murdered at least four of his patients before getting caught. His diary revealed that he killed for the mere pleasure of it. In essence, he was a delusional serial killer. He pleaded guilty to murdering three of his patients by lethal injections. And where was Dr. Swango when arrested? He was in a Chicago airport on his way to Saudi Arabia where he had accepted a job in a hospital.

As the retirement of Baby Boomers will swell the ranks of those receiving Medicare, we need to provide our present Medicare recipients and future ones with the tools to learn about the doctors who will be treating them. Adoption of The Patient Protection Act of 2000 will be an important step in that direction.

Chairman BLILEY. Thank you, Doctor.

We will now hear from our final witness of the day, Mr. Kerry Hicks, Chief Executive Officer of HealthGrades.com, from Lakewood, Colorado.

You didn't get that hand crushed by some doctors out there, did you?

STATEMENT OF KERRY R. HICKS

Mr. HICKS. No, it was me. A biking accident and the wall won.

In the interest of time and hopefully imbibing in some of the products that Mr. Cleary's constituents produce, I will be brief.

I am Kerry Hicks. I am Chairman and CEO of HealthGrades.com, a publically traded company based in Lakewood, Colorado. I appreciate the opportunity to testify on the National Practitioners Data Bank.

By way of introduction, HealthGrades.com's mission is to provide comprehensive, objective health care ratings information to consumers to help them make better-informed health care decisions. We provide to consumers, for free, ratings information on virtually every hospital, physician, health plan, nursing home, home health agency, fertility clinic and hospice program in the Nation. Therefore HealthGrades is 100 percent behind any effort, including this effort, to provide health consumers any straightforward, actionable information that will help them make better-informed choices and improve patient safety.

There is considerable demand for information about the quality of care delivered by the Nation's health care professionals and institutions. Research commissioned by HealthGrades shows that 96 percent of consumers want more information about their health care providers. Approximately 600,000 users have used our Web site to find objective, third-party information about health care providers in the past 3 months, illustrating the significant demand for this type of information.

Consumers need this information to ensure their own safety and that of their loved ones. You have heard today from the first panel of victims who would be in either better health or have family members alive today had they had access to the information in the NPDB. Consumers can find limited physician profile data, such as a doctor's name, address, specialty, medical school, years in practice and State sanctions at a number of locations on the Internet, including numerous State medical board Web sites at HealthGrades.com, but—and this is an important but—malpractice history is simply not available to the public today. State-sanctioned data alone doesn't offer consumers a fair representation of a physician's practice record.

The New York Daily News ran a series of reports in March of this year that found that only 36 percent of physicians in New York who had made at least 10 malpractice payments had faced any disciplinary action by their State medical boards. To say this in the converse, in other words, 64 percent of physicians with 10 or more malpractice payments had not been sanctioned.

It would be disingenuous for anyone in this room to say that they would not want to know that a physician they or a loved one was considering seeing had made 10 or more malpractice payments. Opening up the NPDB would provide this valuable information regarding malpractice payments to the public.

The American Medical Association believes that releasing the raw data from the NPDB would not be helpful to consumers, it might be harmful should they misconstrue or fail to understand the reasons for a physician's malpractice record. We find this, candidly, somewhat incredible. If context is truly the problem, the answer then is not to deny consumers information; it is simply to provide them more information. To dispel the AMA fears, physician malpractice history should be compared to the histories of other physicians practicing the same specialty in the same State. Such com-

parisons would help consumers fully understand the context of the information.

The State of Massachusetts Board of Registration in Medicine has successfully implemented a system with its qualifying information that presents physicians' malpractice history in an easy-to-understand format. Chairman Bliley's legislation, which is based on the Massachusetts model, also achieves this goal.

In addition to putting in payment history in the context of specialty, HealthGrades believes, in fairness, it would be beneficial to indicate how long a physician has been in practice. Three malpractice payments in 15 years might be different than three malpractice payments made in 2 years.

Two states, Massachusetts and Florida, have made great strides in making malpractice history available. All other States that provide physician profile information do not, that is, do not provide malpractice histories. It is important to release this information at the national levels since poor quality physicians have historically been very adept at moving from State to State.

HealthGrades is a private sector company whose business is based on providing consumers with objective third-party ratings and profiles on health care providers. The release of data in the NPDB would allow us to present this key information which could affect the lives of the more than 2.4 million consumers who come to our site each year. It is not the single source by which patients need to make a decision, it is part of a larger profile that we believe is helpful.

As consumer advocates, therefore, we strongly support passage of the Patient Protection Act of 2000. Again, we applaud Mr. Bliley's efforts and thank you for the privilege of addressing this committee.

[The prepared statement of Kerry R. Hicks follows:]

PREPARED STATEMENT OF KERRY R. HICKS, CHAIRMAN AND CEO,
HEALTHGRADES.COM, INC.

Mr. Chairman and Members of the Committee, my name is Kerry Hicks and I am Chairman and CEO of HealthGrades.com, a publicly-traded healthcare information company based in Lakewood, Colorado. I appreciate this opportunity to testify on the National Practitioner Data Bank (NPDB).

HealthGrades' mission is to provide comprehensive, objective healthcare ratings and profiles to consumers to help them make better-informed healthcare choices. We provide to consumers report cards on hospitals, physicians, health plans, nursing homes, home health agencies, fertility clinics and hospice programs (see Attachment 1 for home page). HealthGrades is 100 percent behind efforts to provide the health care consumer with straightforward, actionable information that will help them to make better healthcare choices and improve patient safety.

There is considerable consumer demand for information about the quality of care delivered by the nation's healthcare professionals and institutions. Research commissioned by HealthGrades shows that 96 percent of consumers want more information about their health care provider. Approximately 600,000 users have used our Web site to find objective, third-party information about a healthcare provider in the past three months, illustrating the significant demand for this information. Consumers need this information to ensure their own safety and that of their loved ones. You have already heard testimony from victims who would be in better health or have family alive today had they had access to the information in the NPDB.

Consumers can find limited physician profile data such as doctor's name, address, specialty, medical school, years in practice, and state sanctions at a number of locations on the Internet, including numerous state medical board Web sites and HealthGrades.com (see Attachment 2 for physician profile example). But, malpractice history is simply not available to the public.


State sanction data alone does not offer consumers a fair representation of a physician's practice record. The New York Daily News ran a series of reports in March 2000 that found that only 36 percent of the physicians in New York who had made at least 10 malpractice payments had faced disciplinary action by their state medical board. In other words, 64 percent of the physicians with 10 or more malpractice payments had not been sanctioned! It would be disingenuous for anyone in this room to say that they would not want to know that a physician they, or a loved one, was considering seeing had made 10 or more malpractice payments. Opening up the NPDB would provide this valuable information regarding malpractice payments to the public.

The American Medical Association believes that releasing the raw data from the NPDB would not be that helpful to consumers, and might even be harmful, should they misconstrue or fail to understand the reasons for a physician's malpractice record. If context is truly the problem, then the answer is not to deny consumers information, but to give them more. To dispel the AMA's fears, physicians' malpractice histories should be compared to the histories of other physicians practicing in the same specialty and in the same state. Such comparisons would help consumers fully understand the context of the information.


The State of Massachusetts Board of Registration in Medicine has successfully implemented a system with this qualifying information that presents physician malpractice history in an easy-to-understand format. Chairman Bliley's legislation, which is based on the Massachusetts model, also achieves this goal. In addition to putting payment history in context of specialty and state, HealthGrades believes that, in fairness, it would be beneficial to indicate how long a physician has been in practice. Three malpractice payments in 15 years might be different than three malpractice payments in two years.

Two states, Massachusetts and Florida, have made great strides in making malpractice history available. All other states that provide physician profile information do not provide malpractice histories. It is important to release this information at the national level since poor-quality physicians have historically been very adept at moving from state to state to escape detection.


HealthGrades is a private company whose business is based on providing consumers with objective, third-party ratings and profiles of healthcare providers. The release of the data in the NPDB would allow us to present this key information, which could affect the lives of the more than 2.4 million consumers who come to our site each year. As consumer advocates, we strongly support passage of the Patient Protection Act of 2000. Thank you for the privilege of addressing this committee.




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
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
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
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
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Chairman BLILEY. Thank you very much.

The Chair recognizes himself.

Mr. Croft, you testified that the modification of the current NPDB would be a major undertaking that would take 2 to 3 years. The State of Massachusetts, which has one of the largest physician populations in the country, created their system from scratch in 6 months with essentially no budget and no model.

Are you really claiming that the Federal Government with its vast resources will take 3 years to model the system on Massachusetts using data that for the most part it already collects?

Mr. CROFT. Well I think that is one of the important points, Mr. Chairman, that in fact we do not have some of the data that your legislation would call for; and I am not sure, unless we were starting from scratch, that we could ever collect some of that data to the point where it would be considered reliable. After all, we have got 10 years' worth of information, and much of it comes from malpractice insurers, some of whom are no longer in business. And not to mention the regulatory process that the Federal Government uses which, as we all know, is not the speediest in the world.

But just as a general observation, if we were talking about starting a new system from scratch, forgetting about the regulatory side of things, it probably would be easier, actually, than modifying an existing system that was set up for one purpose, to use it for an entirely different purpose. That is my best professional estimate about the time, and based on my experience, that is probably of what it will take.

Chairman BLILEY. You testified that congressional intent in 1986 was quite clear that the Data Bank's information is not intended to produce an independent determination about the competency of an individual practitioner. As such, the Data Bank information is incomplete for the purpose of disclosure.

Are you aware that Vice President Gore played a large part in the original legislation?

Mr. CROFT. No, I wasn't.

Chairman BLILEY. Please look at the poster over there to my right. The Vice President said, "My natural inclination is to make it available to the public. It is my understanding we set out to make it available to everybody, and at some point it was cut back."

Mr. Croft, do you think the Vice President is wrong in his recollection—in his current view that he is inclined to open the Data Bank to the public?

Mr. CROFT. I have no reason to question that, sir. I would simply say that it is my understanding that this act would probably have never been passed without those confidentiality provisions. And Mr. Gore's intentions notwithstanding—

Chairman BLILEY. Another question on the clarity of congressional intent in 1986: That did not stop the administration from proposing access to the Data Bank 7 years later in 1993, did it?

Mr. CROFT. Apparently not.

Chairman BLILEY. Thank you.

One question for you, Ms. Henderson: Is Tillis Churchill's physician, Dr. Butler, still practicing in Florida?

Ms. HENDERSON. I can't speak to that. I don't know. But I made a note, and I certainly will find out tomorrow.

Chairman BLILEY. Good. If you could let the committee know we would deeply appreciate it.

The Chair yields back the balance of his time and recognizes the gentleman from Ohio, Mr. Strickland.

Mr. STRICKLAND. Thank you, Mr. Chairman.

I would like to ask this question, and any or all of you could respond if you like. In the AMA's testimony, it is mentioned that according to 1999 NPDB data, cumulative data in that annual report showed that at the end of 1999, 75.8 percent of all NPDB reports pertained to medical malpractice settlements.

The AMA also states in their testimony that at least two studies suggest the correlation between settled claims and actual negligence is around 30 percent.

What do these findings suggest regarding the release of any data on malpractice claims, in your judgment?

Ms. SULLIVAN. I can give you some information from Massachusetts that might—I hope will be helpful for you.

I think that the significant issue is not the huge percentage of doctors who have a single malpractice payment. I did a 10-year analysis of a data base on what we have on Massachusetts physicians, in expectation of questions on malpractice, in an annual average population of about 30,000—so our current licensees—we have only 105 who have had more than two paid claims. And that was actually out of a total population, over 10 years, of over 40,000 doctors. But these are physicians who represent 5 percent of the population of physicians who have a paid claim. So 95 percent obviously have two or fewer, two or one, and represent only one-third of 1 percent of all of our doctors who account for 16 percent of the dollars paid.

And to get to your question, how do we measure whether or not—if that affects quality, these physicians tend to be very problematic in other areas. These 105 with three or more paid claims had 334 consumer complaints, 99 hospital discipline reports, 25 board disciplinary actions, 16 complaints from health care professionals or reports from government or law enforcement. And we found that—and perhaps the Massachusetts population is a statistical anomaly—that regardless of the area of specialty, any time that a physician had a record of greater than three malpractice payments, regardless of settlement or judgment, that that physician was a statistical outlier of great magnitude for that speciality.

Mr. STRICKLAND. Let me ask a related question here.

Do you or Mr. Hicks or any others believe that certain States are allowing bad doctors to practice when they should not be practicing? I know—I am from the State of Ohio; I believe our State has a reputation for doing a superb job of monitoring physicians and taking this matter very, very seriously.

But do you think that States are allowing these bad practices to happen, and if so, what's breaking down? Do States knowingly do this, or are there other reasons?

Mr. Hicks, I would especially like to ask you what the root causes are if this in fact is happening, if States are doing this or not taking this problem seriously.

Mr. HICKS. Sure. I appreciate the question, and my answer will be somewhat speculative; but certainly our experience is, if you

look at the State medical boards, there is substantial variability amongst the States, which is not altogether unanticipated from the standpoint that there are States that are much more rigorous, if you look at their experience and the percentage of sanctions per physician or per thousand procedures and the like.

But, you know, if there is an introduction with respect to trying to make all 50 States walk in lockstep under the same terms and conditions, I mean, I frankly believe that that is improbable.

Mr. STRICKLAND. Would any of the others like to comment on that, on your perception of what the States are doing?

Ms. HENDERSON. I would like to comment that I think in Florida our medical board takes their public protection responsibility very seriously; and I see giving certain information to consumers as more of a partnership that really enhances that public protection mission.

Consumers have a vested interest in helping us make sure we get it right. And so it is more, to me, of a comprehensive package; there is no single one way that is the correct way. And so we look at it as a multidimensional approach to public protection, and consumers having information is certainly a step in the right direction.

Chairman BLILEY. The time of the gentleman has expired.

The Chair recognizes the gentleman from Iowa, Dr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman. It has been a good hearing, and I appreciate your having this hearing and the members of this panel waiting a long time.

It has been an amazing day when Hillary's health plan is brought up on the chart here, and Chairman Bliley is touting an aspect of it; I thought that would be a cold day somewhere.

But in answer to your question, Mr. Cleary, maybe I can provide some useful information. You wanted to know how I would find a good doctor.

Mr. CLEARY. Yeah. My point was, you know, in the old days we used to be able to rely on that because we weren't as transient. We were born and died in the same town, and I mentioned the small town I grew up in. Everybody knew who the occasional bad doctor was. But now we are so transient, it is hard; and when you find yourself in a new city and place, how do you find out? People often move from city to city to city.

Mr. GANSKE. That is true. And part of the problem is that employers switch HMOs so frequently that once you establish a relationship with someone on a panel, then the next year you find you are in a totally different HMO. And that type of transient decision-making by employers is a real problem.

Mr. CLEARY. If I may, what's wrong with that is quality. The biggest problem our employers make is keeping workers—hiring and keeping workers, and we do that by providing the best benefits. And so we listen to them, and if there is a plan that is not working, very often we hear from our employers, they switch the plans. That is what's driving that.

Mr. GANSKE. I think it is also fair to say that many employers look primarily at the bottom line and the cost of the contract.

Mr. CLEARY. The bottom line involves the people—

Mr. GANSKE. Let me give you some advice, Mr. Cleary, on how to find a good doctor, especially if you are looking for surgery.

Mr. CLEARY. I am not yet, that I am aware of, but go ahead.

Mr. GANSKE. Some day if you do.

I was always very honored when I was in practice as a surgeon, when I asked my patients how they happened to come to me, if they said, Well, I have a friend who is a nurse in one of the operating rooms, and she told me that I ought to come and see you. I thought that was a real high compliment, and so if you have any friends who are nurses in operating rooms, you can ask them.

I am going to close, Mr. Chairman, by quoting—I think maybe to bring this to a close, by quoting from an article, one of the two articles that the Institute of Medicine used in its report on medical errors; and this is the nature of adverse effect events in hospitalized patients from the New England Journal of Medicine by Lucy Ann Liepen and others, volume 324. And the first part of the discussion I think is really pertinent today.

And this is what it says, because it is important, I think, to distinguish between medical errors and negligence:

“Many of the adverse effect events we identified were neither preventable nor predictable, given the current state of medical knowledge. For example, idiosyncratic drug reactions in patients who had not taken the drugs previously—how could you ever know—postoperative myocardial infarctions in young patients without previous evidence of heart disease; and adhesive intestinal obstructions, other unpreventable adverse events occurred with predictable frequency. But the patients accepted the risk of treatment because of the potential benefits. Examples of these include radiation injury and bone marrow suppression from chemotherapy. Preventing these unpreventable adverse effects events will require advances in biomedical knowledge.”

I might add, for instance, that somebody who is grossly overweight and requires bariatric surgery, that person is at significant risk for a whole series of health events that could shorten his life. But at the same time you have to weigh that against the fact that an operation could be fatal, too.

This goes on to say, “Our physician reviewers identified management errors in more than half of the adverse events we studied. Technical errors were by far the most common class of error but relatively few of these were judged to result from negligence.”

It goes on to say, “Sometimes the evidence of negligence appears clear-cut, as when a physician fails to evaluate a patient with rectal bleeding. Other cases are less obvious. For example, depending on the circumstances, each of following could be considered either negligent or not: a mistaken diagnosis of acute appendicitis; misinterpretation of a chest film as pneumonia, instead of showing congestive heart failure; puncture of the pleura during insertion of a central venous catheter; perforation of a bowel during an operation to remove adhesive intestinal obstruction.

“In the case of the mistaken diagnosis of acute appendicitis”—Mr. Chairman, may I have about 30 seconds?

Chairman BLILEY. Without objection.

Mr. GANSKE. “the patient may have had a classic history, typical findings on physical exam, laboratory tests supportive of the diagnosis. If the physician then failed to make the diagnosis, it would be both an error in diagnosis and a case of negligence. If, however,

the diagnosis was made, but no appendicitis was found, there would have been an error in the diagnosis, but not one involving negligence because a surgeon would have followed generally accepted practices, standards of practice.”

These are the types of considerations that I think need to be placed into context, particularly when we are dealing with settlements. And I thank the chairman very much.

Chairman BLILEY. The Chair recognizes the gentleman from Massachusetts, but it would also, before recognizing him, point out to the gentleman from Iowa that the Chair had his appendix removed with a misdiagnosis and almost died when he was 13 years old—and some probably wished I had.

Anyway the Chair recognizes the gentleman from Massachusetts, Mr. Markey.

Mr. MARKEY. Thank you, Mr. Chairman, very much.

Ms. Sullivan from Massachusetts, my mother is a Sullivan, and she always told me the Sullivans are a very intelligent people.

Ms. SULLIVAN. Your mother is a very wise woman.

Mr. MARKEY. Especially those from Massachusetts.

Ms. SULLIVAN. She is doubly wise.

Mr. MARKEY. You are here to help illuminate the committee on how wise the Sullivans of Massachusetts are in implementing this kind of a Data Bank in our home State. We have a 800 number in Massachusetts, and we also have a Web site that people can go to. Which of those two do people more frequently use, the Web site or the 800 number?

Ms. SULLIVAN. When we first started, we started with only the 800 number; and when I testified here March 1, I actually included in my testimony a breakdown of the exact numbers. But the usage of the Web is significantly higher.

Mr. MARKEY. Significantly higher?

Ms. SULLIVAN. Significantly higher. I don't know the exact numbers. We are projecting for this year in the vicinity of 3 to 3.25 million hits on our Web site, into our profile system, and I would say that we will probably take 40,000 phone calls on it.

Mr. MARKEY. So would you recommend that any legislation that we pass on a national basis include an 800 number and a Web site requirement?

Ms. SULLIVAN. Yes, I would, and because it is a work in progress, among the things that we hope to add on our Web site is a Spanish language mirror in that we do have staff who have additional language capability to work in the call center.

We do not want to exclude anyone who might need our services, and any time you have multiples of 10,000 of U.S. Citizens that need your help, I think it indicates that it is an important thing.

Mr. MARKEY. I think it is a good idea.

Ms. SULLIVAN. May I add one thing to that, Mr. Markey?

Our staff, during our lunch break I called the office, and they were watching C-SPAN and they asked me to say thank you to you for your kind words during your opening statement; they felt you showed great support for their public service and they were grateful for that.

Mr. MARKEY. Well, I am sure anyone who would be hired by a Sullivan would automatically be an excellent person, and I will

only continue to reflect that attitude which my mother built deeply into me.

Ms. SULLIVAN. I hate to tell you it is my ex-husband's name, but continue.

Mr. MARKEY. I actually knew that but wasn't going to mention that on C-SPAN, but I suppose everyone back in the office knows as well.

Ms. SULLIVAN. You've made my mother very happy. Thank you.

Mr. MARKEY. The marriage or the divorce—

Ms. SULLIVAN. Continue.

Mr. MARKEY. [continuing] or the name?

Now you have this requirement, I think, in Massachusetts that the specific dollar amount of the malpractice claim is actually not part of the information. And that, I understand it is a way that makes it, as a result, more difficult to identify who the specific claimant may be.

Ms. SULLIVAN. To some degree.

Actually, I will say probably no, because the majority of doctors who have a payment and any malpractice history in Massachusetts have a single payment. And the court reports of the docket numbers, including the plaintiff name, are of course public record, so anyone doing a diligent search could actually look it up.

But I think that the privacy concerns that you raised in your opening statement are very valid, and I think it is something that we should all have on the table at all times when we look at whether or not, as people become more and more sophisticated in layering of data bases and overlays, to become more and more specific as to whether or not it would be a violation of privacy for people.

You have a good suggestion.

Mr. MARKEY. So the biggest concern I hear from members is that this information could be misinterpreted, that is, that they could gain access to it and not really understand what the nature of the claim was; that is, someone from Texas looking at Massachusetts wouldn't understand Massachusetts laws, wouldn't understand what the standards were in order for a complaint to be brought against a physician.

Or Massachusetts looking at Texas, that there might be a ceiling of a million dollars for a case, whereas in Massachusetts there would be no limit in terms of someone being able to sue a doctor.

How do we sort that out if we are going to construct a national system? What is a way we can make sure the information is not misinterpreted, in a way it would not harm the doctor on the one hand, or on the other hand give the patient or the potential user of the service a misimpression as to whether or not the doctor was really qualified or not.

Ms. SULLIVAN. If I had the ability to add the other States' information to ours for a doctor of multilicense, I would create a table that had significant information about any caps, whether or not there was a tribunal system; and there would be significant patient information on the other States that simply populate from the table as an explanation to each field to make it more clear.

I think it is a very easy technical answer, but an important policy issue.

Mr. MARKEY. If I may ask one final question, Mr. Chairman——
Chairman BLILEY. Sure.

Mr. MARKEY. What, in your opinion, is the quality of the information which is being put on the Massachusetts system, that is, the quality of the information from physicians, from hospitals, from all the sources? Is there a way you can rank in the hierarchy which information in your opinion is most solid and which is least solid?

Ms. SULLIVAN. The most solid is malpractice. We have three sources with cross-verification for that. Our own board records of discipline are easy to maintain. We don't have great compliance or ability right now to keep insurance plans and other things updated, although we have recently come to some negotiations with a few of the major plan members that they will download their files to us directly, so that we have very current information.

The most important quality information, and I say this as the person who 4 years ago implemented—I was the technical project manager on this implementation, our board records had an 80 percent error rate on them—8-0, 80. Our error rate is under 2 percent in the same files now. That is because it has to be right.

The degree to which it is important, you have to hear that, it forces you to care about the quality of your data. Thank you.

Mr. MARKEY. As expected, Mr. Chairman, superior testimony being delivered to this committee; and I hope that all members will take it under advisement because I think that will help us to frame the national legislation.

Chairman BLILEY. I thank the gentleman, and I want to thank the panel and all of our witnesses today for their superb testimony. We are deeply grateful.

This concludes the hearing.

[Whereupon, at 4 p.m., the committee was adjourned.]

[Additional material submitted for the record follows:]

FAMILIES ADVOCATING INJURY REDUCTION
September 26, 2000

To the Members of the Subcommittee on Commerce
RE: H.R. 5122, The Patient Protection Act of 2000

I'm writing on behalf of the 2,800 members of Families Advocating Injury Reduction (FAIR). FAIR is an Illinois statewide organization made up of victims and their families who have suffered a loss of a loved one or a devastating injury because of medical negligence, unsafe workplaces, and dangerous products.

We support of the opening of the National Practitioner's Data Bank. We believe that the patient has the right to know the professional background of a physician that they are choosing for themselves and their families. Increasing reliance on the marketplace for the delivery of health care has dramatically altered the patient-doctor relationship. The family doctor has been replaced by a far reaching networks of physicians whom consumers often know nothing about.

If patients are to become effective consumers in the health care marketplace, they must have access to information about the care they are purchasing. Recognizing this need, we believe opening the National Practitioner's Data Bank would give the consumers the information needed to make educated and safer choices.

RUTH WYMAN
FAIR Coordinator

414 SOUTH NINTH AVENUE
LA GRANGE, IL 60525
September 25, 2000

To the Members of the Subcommittee on Commerce
RE: H.R. 5122, The Patient Protection Act of 2000

I would like to submit this testimony to the members of the Subcommittee on Commerce for their consideration on the subject of opening up the National Practitioner's Data Bank. I am a victim of medical malpractice, injured by a doctor who was incompetent and unethical. Because of our state's inability to monitor and discipline problem doctors, this doctor has a clean and active license, according to the Illinois Department of Professional Regulation (DPR).

In reality, this doctor had two peers reviews on my behalf. He's been sanctioned by his medical society for unethical conducted, exploiting his patient for financial gain, for what he did to me. I decided not to file a lawsuit but he has several malpractice lawsuits filed against him. One lawsuit was filed at \$4.5 million for the wrongful death of a young woman. It was settled for a sizable amount and sealed.

I went to my state Senator, Senator Raica, to talk to him about this doctor and about the Department of Professional Regulation (DPR) not doing its job. Senator Raica already knew about this doctor. His legislative aid told me what this same doctor did to her family member. Our complaints were very similar. Although she never reported it, it revealed a pattern of problems with his conduct. This doctor was also investigated by another state agency that looks internally at hospitals for problems after several similar complaints came in against him. Our local paper reported that a nurse at his building was assaulted, hit on the head with a blunt object, by a disgruntled patient who made a threat against this doctor's life for what he did to him.

If a patient is able to know the complete professional background of this physician, I am confident that this doctor would not be their choice. Although some of the incidences that I mentioned would not be reported to the Data Bank, the sanction, lawsuits and peer reviews would reveal his true character. A patient has the right to know about the doctor that they are entrusting themselves to.

Because of my bad experience, I became very active and tried to improve our health care system in Illinois. I would like to present Illinois as an example of why we need H.R. 5122

I became a member of Families Advocating Injury Reduction (FAIR) and worked on getting a Patient's Right To Know Act passed in Illinois. This bill is fashioned after the Massachusetts profiling bill. Since 1997, when it was first introduced, the Illinois State Medical Society fought hard to block our access to our physician's professional background. Just this past spring, it was introduced again and failed in committee.

The Illinois State Medical Society came out against it, claiming that the public is too ignorant to understand and process the information. Like children, the public needs to trust them, unconditionally. They don't seem to understand that children can be taught. The Department of Professional Regulation (DPR) has been under attack for scathing audits by the Illinois Auditor General as an agency not capable for doing its job. Illinois is ranked as one of the ten worst states in the nation for protecting patients against bad doctors, according to Public Citizen.

The Department of Professional Regulation (DPR) testified at the committee hearing this spring that physician profiling would cost the state \$1.8 million to set up. This is obviously ludicrous. But because of the political power of the Illinois State Medical Society, it was voted down.

In testimony for the Patient Protection Bill of 2000, the AMA states that they are for profiling but only if it's done at the state level. Looking at the recent vote in Illinois, I would say that this is not a true statement. It's a statement to delay our right to know about our physician's background. I only want to know about my doctor as much as I can find out about my roofer or my TV repair man.

My life will never be the same because of what this doctor did to me. With information and better choices, our health care will improve. I believe that the incidents of medical errors and medical negligence will drop with the opening up of the National Practitioner's Data Bank because of the patient's ability to make more informed and safer choices.

ARLENE SALAMENDRA

337 ALFRED DRIVE
SYCAMORE, IL 60178
September 26, 2000

To the Members Of the Subcommittee on Commerce
RE: H.R. 5122, The Patient Protection Act of 2000

In the last fifteen years, we have found out that our son was exploited by a doctor at three months of age. This man stepped out of the standard of care many times. The injury to our son's airway and bronchus led to a cardiac arrest which led to

a brain injury. Had it not been for disclosure at a back surgery as a teenager, we would still not have known about our son's injuries. The cover-up led to many strange deceptions, one of which was unnecessary allergy shots. There were even isotope lung scans done on our young child, behind our backs. We believe that this was to assess the damage that had been done. It is almost as if the medical professionals had charge of our child.

We attempted to get our son's case into the courts. First there was obstruction by a friend of the doctor who did this to our son. Then after we found representation despite this man's efforts to keep us out of the system for five years. The same man showed up in our case and coerced our attorneys into giving up a case that withstood numerous motions and even an appellate court decision.

In Illinois, the Illinois State Medical Society gives millions of dollars in campaign finance funds to politicians. We also have the presence of a powerful politician who has appointed his sister as a deputy director of our state agency that controls licensing and he supposedly controls elections, all this for about twenty years now!

We must look to a federal level for changes, as the same kind of situations probably exists in other states to varying degrees. Though we believe that Illinois has all this down to a science. It is no wonder that we are 43rd in the nation for disciplining bad doctors. We need to raise this "Veil of Secrecy" so that people may have a choice to avoid the really bad doctors. We need to have standardized disclosure laws that have some teeth in them. All these things on a federal level would keep doctors from covering up, and then moving into other state to practice medicine!

Our lives have been destroyed by a bad doctor and the cover-up that followed us all the way into the court system. Our son Aaron had his right to "due process" stolen from him by October 1, 1997.

HERBERT AND GERALDINE SCHRYVER

316 N. MACOUPIN
GILLESPIE, IL 62033
September 25, 2000

To Whom It May Concern:

- December 1995, injured by a doctor
- Jan. 4, 1996, Newspaper announces that doctor is leaving the community for southern Illinois (Marion)
- Feb. 1996, file complaint with state Department of Professional Regulation (DPR)
- Jan. 1996, doctor gave up status as an Illinois State Medical Society doctor
- Mar. 1996, doctor no longer listed as a provider under Health Link Insurance
- Within first 6 months at Marion, seriously injures 4 women
- Sept. 1996, DPR decides the doctor has committed no violation in my case
- I appeal decision and am denied access to complaint and appeal record
- Aug. 18, 1998, I resubmit complaint in writing to DPR
- Receive letter from DPR director stating that decision stands
- Dec. 1998, DPR finally disciplines doctor for injuries in Marion, though patient contact is still allowed

Please include the following testimony in support of opening up the National Practitioner's Data Bank to the Public, a bill that Rep. Tom Bliley held hearings on September 19, 2000.

I am a victim of medical negligence. In the Fall of 1995, I was looking for a doctor to see. Because I had very good insurance, I did not need any referrals. I looked through the local yellow pages and found a doctor who advertised "20 years of practice." I assumed that this doctor was good. What reason would I have to not think so?

What I experienced under this doctor's care is nothing short of gross negligence and I think it is criminal too. Unfortunately, the doctor preferred to cover up his mistakes and move on, rather than treating me for the problems that he left me with. For two years, I couldn't even leave my house, I was so sick.

Within a month after this doctor treated me, I saw an announcement in our local small town paper that he was leaving town and heading to southern Illinois. I got scared thinking about all the young women he would be treating in this college community who didn't have their families with them.

When I went to a new doctor in St. Louis, MO, the doctor looked at my medical records and at me, and told me that I should report this doctor to the proper authorities. I filed a complaint over the phone with the Department of Professional Regulation (DPR). While my case was closed without any action, a diplomat of the Medical Society in my community told me that he and other doctors had stopped

referring their patients to him. As I met more women in my community, I heard horror stories of what these women had encountered from him. These stories made me even more worried about his patients in southern Illinois.

Working with FAIR: *Families Advocating Injury Reduction*, a victims rights organization here in Illinois, we looked up the public records of this doctor in some of the court houses. We found that this doctor had paid out more than \$700,000.00 in medical malpractice settlements in McHenry County in northern Illinois. Then he came to my area and injured me and several other women. I tracked this doctor down to Marion Illinois and found out that he was suspended from hospital privileges after injuring four women in a six month time period.

But what did his record say? If you would have called the Illinois Department of Professional Regulation (DPR), they would have told you that his record was in "clean and good standing." They would not have said anything about his malpractice payments that we—just by chance—found out about in McHenry County. They would not have told you about his suspension from hospital privileges at Marion Memorial Hospital. And you would have thought that you were getting a true picture of this doctor's professional history.

But you weren't.

As an Illinois tax-payer, I have seen our own state's DPR go through two scathing audits and do little but turn a blind eye and a deaf ear to the problem of consumer access to medical providers' professional record. They still deny people access to information, and lobby against access when the issue comes up for a vote in the state legislature.

So I'm asking you, for me, for my daughter, and for all the other people in this country who want to find out the truth about our medical providers before it's too late, please open up the National Practitioner's Data Bank to the public. It's our tax dollars, and most of all, it's our lives on the line.

Sincerely,

JEANNE BOUILLON

P.S. Please see enclosed map for more information.

The travels and tragedies of Dr. Dickstein

